

Georgia State University

ScholarWorks @ Georgia State University

Gerontology Theses

Gerontology Institute

12-13-2018

A study of low-income black women and the change of life

Pamela Manley

Follow this and additional works at: https://scholarworks.gsu.edu/gerontology_theses

Recommended Citation

Manley, Pamela, "A study of low-income black women and the change of life." Thesis, Georgia State University, 2018.

https://scholarworks.gsu.edu/gerontology_theses/43

This Thesis is brought to you for free and open access by the Gerontology Institute at ScholarWorks @ Georgia State University. It has been accepted for inclusion in Gerontology Theses by an authorized administrator of ScholarWorks @ Georgia State University. For more information, please contact scholarworks@gsu.edu.

A STUDY OF LOW-INCOME BLACK WOMEN AND THE “CHANGE OF LIFE”

by

PAMELA R. MANLEY

Under the Direction of Candace Kemp, Ph.D.

ABSTRACT

Perimenopause is a significant, transitional event in the life span of women. To date, most empirical research has focused on the experiences of middle-class Caucasian women, while the experiences of low-income black women have largely gone understudied. This qualitative study is one of few studies published in the past 20 years that investigates the perimenopausal experiences of low-income black women. I used an intersectionality framework to explore the lived experiences of eight low-income black women recruited from a large, urban city in the southeastern U.S. The main research question guiding the study was: How do low-income black women perceive and manage the menopause transition? Secondly, the study investigated how this sample of participants interpreted and made meaning of their perimenopausal experiences in the larger context of aging. Digital audio recordings of face-to-face interviews were transcribed

verbatim and analyzed using N-Vivo 12. Based on an interpretative phenomenological approach, an iterative coding strategy produced five dominant themes: a lack of knowledge about menopause; a need for more information and resources from doctors; managing vasomotor symptoms, sleeplessness, and mood lability; an acceptance that menopause is a natural part of life; and positive views toward aging. Research findings have implications for healthcare and mental health practitioners tasked with addressing the health-related quality-of-life concerns of midlife minority women. Gerontologists studying reproductive aging issues in racially diverse populations will also glean important insights from this qualitative study (e.g., black women's menopausal experiences are often embedded in a larger context of chronic health issues and health disparities).

INDEX WORDS: Perimenopause, Black women, Lived experiences, Intersectionality, Aging

A STUDY OF LOW-INCOME BLACK WOMEN AND THE “CHANGE OF LIFE”

by

PAMELA R. MANLEY

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2018

Copyright by
Pamela R. Manley
2018

A STUDY OF LOW-INCOME BLACK WOMEN AND THE “CHANGE OF LIFE”

by

PAMELA R. MANLEY

Committee Chair: Candace Kemp

Committee: Elisabeth Burgess

Committee: Fayron Epps

Electronic Version Approved:

Office of Graduate Studies

College of Arts and Sciences

Georgia State University

November 2018

DEDICATION

This research is dedicated to black women and other women of color who live at the intersections of race, gender, class, midlife, and other social identities. Your experiences matter. Your voices will be heard.

ACKNOWLEDGEMENTS

I would like to acknowledge and thank my thesis committee for their ongoing guidance and support of this important research project: Dr. Candace Kemp, chair, and committee members Drs. Elisabeth Burgess and Fayron Epps. I sincerely appreciate your feedback, recommendations, and your valuable time! I also thank my participants for volunteering to participate in my research. As a qualitative researcher, I believe the voices of understudied and underserved populations matter and should be heard. Last, but not least, I want to acknowledge and thank Branch Manager Emma Laster for taking an interest in my research and granting access to the library meeting room where most of the interviews were conducted. By conducting and publishing the findings from this study, I trust more research will be conducted of low-income black women and their unique lived experiences.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	V
LIST OF TABLES	X
LIST OF FIGURES	XI
LIST OF ABBREVIATIONS	XII
CHAPTER 1 INTRODUCTION AND OVERVIEW.....	1
1.1 Background of the Study	2
<i>1.1.1 Problem statement.....</i>	<i>2</i>
1.2 Purpose of the Study	3
1.3 Research Questions & Methodology	3
1.4 Assumptions & Limitations.....	4
<i>1.4.1 Scope & delimitations</i>	<i>5</i>
1.5 Gerontological Significance.....	6
1.6 Anticipated Results	7
CHAPTER 2 THEORETICAL FRAMEWORK AND LITERATURE REVIEW....	7
2.1 Intersectionality Framework.....	8
<i>2.1.1 Intersectionality, menopause, & aging.....</i>	<i>11</i>
2.2 Literature Review.....	12
<i>2.2.1 Literature search strategy</i>	<i>12</i>
<i>2.2.2 Menopause terminology & definitions</i>	<i>15</i>
<i>2.2.3 Significance of menopause research.....</i>	<i>17</i>

2.2.4	<i>Racial/ethnic differences among midlife women</i>	18
2.2.5	<i>The medicalization of menopause</i>	21
2.2.6	<i>Menopause & health-related quality of life (HRQoL)</i>	23
2.2.7	<i>Black women & menopause</i>	27
2.2.8	<i>Strengths & limitations of existing research</i>	30
2.2.9	<i>Summary & conclusion</i>	32
CHAPTER 3 METHODS		33
3.1	Introduction	33
3.2	Research design & rationale	33
3.3	IRB Approval	34
3.3.1	<i>Measures for ethical protection</i>	34
3.3.2	<i>Informed consent</i>	35
3.3.3	<i>Confidentiality & anonymity</i>	36
3.4	Recruitment Strategy	37
3.4.1	<i>Inclusion criteria</i>	38
3.4.2	<i>Screening & eligibility</i>	39
3.4.3	<i>Sample characteristics</i>	40
3.5	Data Collection	42
3.5.1	<i>Interview process</i>	43
3.6	Data Analysis	45
3.7	Evidence of Rigor	50
CHAPTER 4 FINDINGS		52
4.1	Introduction	52

4.2	Results	53
4.2.1	<i>Theme 1</i>	54
4.2.2	<i>Theme 2</i>	57
4.2.3	<i>Theme 3</i>	61
4.2.4	<i>Theme 4</i>	64
4.2.5	<i>Theme 5</i>	66
4.2.6	<i>RQs Answered</i>	69
4.3	Summary	75
CHAPTER 5 DISCUSSION AND CONCLUSION.....		76
5.1	Discussion of Findings.....	76
5.2	Strengths & Limitations	79
5.3	Theoretical Implications	80
5.4	Methodological Implications	82
5.5	Practice & Policy Implications.....	83
5.6	Directions for Future Research.....	84
5.7	Overall Summary & Conclusion.....	86
REFERENCES.....		88
APPENDICES		100
Appendix A: Recruiting Flyer.....		100
Appendix B: Screening Tool.....		101
Appendix C: Demographic Check Sheet.....		102

Appendix D: Informed Consent.....	104
Appendix E: Interview Schedule	106
Appendix F: Transcriber Confidentiality Agreement	114
Appendix G: Sample of Line-By-Line Analysis	115
Appendix H: Sample Memo of Interview	117

LIST OF TABLES

Table 2.1 Stages of Reproductive Aging	16
Table 3.1 Personal Demographic Variables.....	41
Table 3.2 SES Variables	41
Table 3.3 Participant Health Characteristics.....	42

LIST OF FIGURES

Figure 2.1 Depiction of intersectionality in terms of race, class, and gender	9
Figure 2.2 EBSCOhost databases searched	13
Figure 2.3 Key search terms and results	14
Figure 3.1 NVivo illustration of concept clusters identified in second-cycle coding process.....	46
Figure 3.2 IPA six-step strategy used in data analysis.....	47
Figure 3.3 Basic node structure generated from initial cycle coding.	49
Figure 3.4 Second-cycle coding generated more narrowly defined concepts.	50
Figure 4.1 Themes identified in a study of low-income black women and the change of life	54

LIST OF ABBREVIATIONS

HRQoL:	Health Related Quality of Life
HRT:	Hormone Replacement Therapy
IPA:	Interpretative Phenomenological Analysis
RQs:	Research Questions
SBW:	Strong Black Woman
STRIDE:	Do Stage Transitions Result in Detectable Effects?
SWAN:	Study of Women's Health Across the Nation

CHAPTER 1 INTRODUCTION AND OVERVIEW

Menopause, colloquially known as “the change of life” (Ballard, Kuh, & Wadsworth, 2001, p. 399) is arguably one of the most universal, biologic experiences of midlife women. Although there is a large corpus of empirical research on menopause, it is perhaps one of the least understood of all physiologic experiences, particularly from a phenomenological standpoint (Moustakas, 1994). The process of menses cessation—from transition, to onset, to postmenopause—has been explored by biomedical scientists, feminist researchers, and even professionals from the mental health field to elucidate this mysterious but natural biopsychosocial phenomenon (Grodstein, Manson, & Stampfer, 2006; Huffman, Myers, Tingle, & Bond, 2005; Im, Lee, & Chee, 2010).

Natural menopause is defined as the cessation of menstruation not caused by surgery or other medical intervention (The North American Menopause Society, 2015). It affects women not only physically, but also impacts their psychosocial health to varying degrees (The Boston Women’s Health Book Collective, 2006). Perimenopause, the period leading to menses cessation, is a critical season of life, characterized by hormonal fluctuations, somatic changes, mood lability, and even shifts in social roles (Ballard et al., 2001). Since menopause and aging are closely related phenomena, it stands to reason that women’s reproductive aging merits increased attention by gerontologists. Just as important is the need for gerontologists and other researchers to investigate the lived experiences of low-income black¹ women, an understudied population (Hughes, Varma, Pettigrew, & Albert, 2015).

¹ Note the racial terms “black” and “African American” are used interchangeably throughout the manuscript.

1.1 Background of the Study

Findings from several longitudinal, population-based studies have expanded researchers' knowledge and understanding of the menopause transition (e.g., the Tremin Research Program on Women's Health [Mansfield & Bracken, 2003]; the Study of Women's Health Across the Nation [SWAN], Sutton-Tyrell et al., 1996/1997; and the STRIDE Study [Do Stage Transitions Result in Detectable Effects?] Hess et al., 2012). Additionally, the literature is replete with studies investigating the signs and symptoms of menopause, hormone replacement therapy, quality-of-life concerns, and women's attitudes toward menopause (e.g., Dasgupta & Ray, 2017; Kline et al., 2014; Trabert et al., 2012; Yanikkerem, Koltan, Tamay, & Dikayak, 2012). Based on mostly quantitative and some qualitative research, much of what is known about menopause and aging has been distilled from the experiences and perspectives of middle-class Caucasian women (e.g., Bowles, 1986). Although recent studies have revealed that racial/ethnic differences indeed exist among women in perimenopause, much less is known and understood about the lived experiences of women of color and how they perceive and cope with this major life transition.

1.1.1 Problem statement

Although a handful of researchers have shed light on racial/ethnic differences among midlife women (e.g., Dillaway, 2016; Dillaway, Byrnes, Miller, & Rehan, 2008; & Nixon, Mansfield, Kittell, & Faulkner, 2001), much of the research published to date has focused on Caucasian midlife women with higher education and incomes (e.g., Dillaway, 2006; Dillaway, 2016; Huffman et al., 2005). A thorough search of articles published in the past 10 years uncovered no qualitative research studies focused exclusively on the experiences of low-income black women in perimenopause. As discussed in Chapter 2, African Americans in general are a

difficult population to access due to recruitment challenges, many of which stem from distrust of doctors, medical institutions, and scientific research (Hughes et al., 2015).

1.2 Purpose of the Study

The purpose of this study was to investigate the lived experiences of a sample of low-income black women navigating the menopause transition. In view of the current healthcare crisis in the U.S., including accessibility, affordability, and ever widening health disparities, this study targeted a sizeable gap in the literature by examining the lived experiences and perspectives of eight low-income black women in midlife, who are experiencing natural menopause. This research is undergirded by the conceptual framework of intersectionality (Crenshaw, 1989, 1991), which critiques the lived experiences of minorities in the context of race, class, gender, and other socially constructed identities.

1.3 Research Questions & Methodology

The main research question guiding the study was: How do low-income black women in midlife perceive and manage the menopause transition? This research question was formulated to elicit the ways in which low-income black women recognize, address, and manage perimenopausal signs and symptoms. A secondary research question framing the study was: How do low-income black women understand and interpret their perimenopausal experiences in the larger context of aging? The secondary research question was aimed at uncovering participants' knowledge and understanding of the menopause transition and the meanings they ascribe to their lived experiences. It is important to address these research questions in terms of lived experience, as low-income black women's perimenopausal experiences and perspectives have received scant attention in the literature, particularly within the past decade.

This study employed an interpretative phenomenological analytic (IPA) approach (Smith, Flowers, & Larkin, 2009) to investigate the lived experiences of low-income black women in perimenopause. As detailed in Chapter 3, I conducted semi-structured, in-depth interviews of eight participants to elicit detailed accounts of the women's perimenopausal experiences and their perceptions of aging. In so doing, I obtained rich, thick descriptions (Geertz, 1973) of the women's narratives and their interpretations of their experiences. My rationale for selecting an IPA methodology was that it gives participants the opportunity to tell their unique stories in their own words and in their own way. Participants' narratives were prompted by carefully crafted interview questions that stemmed directly from the research questions and a thorough review of the extant literature. During the interview process, each participant was allowed time to reflect on and ascribe meaning to her experiences.

1.4 Assumptions & Limitations

Approaching a qualitative study of this nature entailed making a few general assumptions about human behavior and the research process. First, I assumed midlife women who volunteered to participate in the study would be truthful in reporting demographic information (e.g., age, education, income, marital status, menopause status). Second, I assumed participants would be completely candid in disclosing the totality of their lived experiences and voicing their unique perspectives. Third, although participants received a small stipend (i.e., \$25 in cash) for their time, I assumed the amount of compensation would not cause women to volunteer solely for the stipend. That is, I assumed women would desire to take part in the study, even without being compensated.

Next, I assumed participants may not be aware of their menopause status. In my review of the literature, some research findings revealed that participants' lacked knowledge or were

confused about their menopause status and perimenopause in general (Dillaway, 2016; Huffman et al., 2005). During the screening process, I asked callers to disclose the month/year of their last menstrual cycle and to reveal what types of signs and symptoms they were experiencing. Finally, in obtaining consent, I assumed research participants would be willing to accept the risks associated with participating in a study that involved disclosing personal health information. (See Chapter 3 for a detailed discussion of the informed consent procedure.)

The present study has some limitations that should be noted. In terms of sampling, I recruited a small, purposive sample, which is consistent with the IPA method (e.g., Marnocha, Bergstrom, & Dempsey, 2011; Nixon, Evans, Kalischuk, Solowoniuk, McCallum, & Hagen, 2013; Pearce, Thogersen-Ntoumani, Duda, & McKenna, 2014; and West, Stewart, Foster, & Usher, 2012). In defending the IPA approach, Smith et al. (2009) argued, “The primary concern of IPA is with detailed account of individual experience” (p. 51). Moreover, Smith et al. maintained that the emphasis is on “quality, not quantity . . . given the complexity of most human phenomena” (p. 51). Smith et al. further suggested that a sample size of “between three and six participants” (p. 51) is reasonable for most IPA research studies. The authors go on to say that meaningful comparisons and contrasts among participant accounts can still be made using a smaller sample size.

1.4.1 Scope & delimitations

In conducting an IPA research study, it is important to note the scope and delimitations of the study (i.e., limitations preset by the researcher). A detailed discussion of the study’s scope, delimitations, and recruitment strategy is presented in Chapter 3. Due to the study’s methodology and objectives, only low-income, black women from the mid-forties to late fifties were recruited, screened, and interviewed. (See rationale for age range in Chapter 3.) Women who had

undergone a hysterectomy and postmenopausal women were excluded from the study. The rationale for excluding women who had undergone a hysterectomy was that the lived experiences of women experiencing natural menopause may be different than the lived experiences of women who have undergone a hysterectomy (Dillaway, 2016; Pearce et al., 2014). Finally, women who were not English literate were excluded from the study.

Another important delimitation to note is that findings from the study are not intended to be generalized to all midlife black women or other minority populations. Rather, the aim of this IPA study was to give voice to a small sample of low-income black women in perimenopause to gain in-depth knowledge and insight into their lived experiences, and to make comparisons and contrasts within and across cases. Not only is the present study expected to contribute to the qualitative literature related to women's reproductive aging, but it is also expected to build upon the body of knowledge concerning the ways in which low-income black women recognize, understand, and manage the menopause transition.

1.5 Gerontological Significance

For midlife women, perimenopause is a distinct, yet integral part of the overall aging process. It is a natural biological process that impacts every dimension of a woman's life (The Boston Women's Health Book Collective, 2006). Natural menopause is emblematic of reproductive aging, which occurs over a period of years (The North American Menopause Society, 2017). During interviews, participants were asked to voice their thoughts, concerns, and perspectives about the menopause transition in the larger context of aging. In addition, participants were asked to disclose the strategies they used to adapt to the many changes taking place in their bodies.

Applying the theory of intersectionality (Crenshaw, 1989, 1991) as a theoretical framework, participants were asked to ascribe meaning to their perimenopausal experiences in the context of being black midlife women who potentially face issues of racism, sexism, ageism, and socioeconomic challenges such as income and health disparities. Against this backdrop, the present study holds great significance for the interdisciplinary field of gerontology. The study's focus on low-income black women only increases the gerontological significance, because low-income black women in midlife are an understudied and underserved population. Results of the study have implications for minority women's healthcare, the mental health profession, feminist research, and minority aging.

1.6 Anticipated Results

Prior to analyzing participant accounts, I anticipated several familiar concepts or themes to emerge from the data corpus. Based on related studies (e.g., Dillaway et al., 2008; Howell, 2001; Im et al., 2010; Nixon et al., 2001), I predicted the following themes would be salient for low-income black women in perimenopause: resilience, the stoic, strong black woman (SBW) archetype, the importance of faith and spirituality in the face of adversity, and the notion that menopause and aging are subordinate concerns to more pressing issues in the lives of low-income black women, such as racism, sexism, and navigating ongoing financial and healthcare challenges (Gary, Still, Mickels, Hasan, & Evans, 2015; Im et al., 2010).

CHAPTER 2 THEORETICAL FRAMEWORK AND LITERATURE REVIEW

The cessation of menses, including the years leading up to menopause, is a significant biopsychosocial event for midlife women. Over the past several decades, numerous studies—mostly quantitative—have been conducted to investigate the phenomenon of the menopause transition such as signs and symptoms, pros and cons of hormone replacement therapy (HRT),

the impact of menopause on quality of life, as well as women's attitudes toward menopause (e.g., Bowles, 1986; George, 2002; Nosek, 2010). While a fair amount of research has concentrated on the experiences of Caucasian women, much less research has focused on the experiences of women of color, particularly low-income black women.

This chapter proposes the framework of intersectionality (Crenshaw, 1989; 1991) as a theoretical lens for exploring low-income black women's experiences with and views toward menopause and aging. Following a discussion of intersectionality and its application to the present study, this chapter continues with a systematic review of literature published primarily within the past decade that illuminates key aspects of the menopause transition. The chapter concludes with a review of current research on black women's menopausal experiences and a summary of the strengths and limitations of existing menopause research.

2.1 Intersectionality Framework

For the purposes of this study, black women's experiences and perceptions of menopause and aging are situated within the theoretical framework of intersectionality, a black feminist discourse that critiques the intersecting roles of race, class, and gender, (among other social identities), relating to black women's marginalization in American society (Crenshaw, 1989, 1991). The term intersectionality was first introduced by UCLA law professor Kimberlé Crenshaw (1991) to describe how "the experiences of women of color are frequently the product of intersecting patterns of racism and sexism, and how these experiences tend not to be represented within the discourses of either feminism or antiracism" (pp. 1243-1244). Crenshaw and other black feminists, (e.g., Collins, 2000; hooks, 1981), have contended that both the women's movement and the black liberation movement neglected to incorporate the experiences and perspectives of black women who also have suffered from social injustice and political

oppression in the United States. More specifically, black women's personal experiences and sociopolitical grievances were not recognized nor addressed by either social movement (Crenshaw, 1989, 1991).

Although Crenshaw is generally credited with coining the term intersectionality (Bowleg, 2012; Collins & Bilge, 2016), the argument that not all women are white and not all blacks are men, (in reference to the aforementioned social movement's exclusion of black women's unique struggles in the U.S.), was addressed more than a hundred years earlier by historical figures such as Anna Julia Cooper, Ida B. Wells-Barnett, and Sojourner Truth, who, as black women, personally experienced the harsh realities of oppression and racial discrimination during their lifetimes (Gines, 2011). Irrespective of the original authorship, the main thrust of intersectionality theory is that race, gender, class, sexuality, and other social identities are not stand-alone entities to be analyzed separately and distinct from individual experience; rather, they are intersecting and interlocking social identities that directly impact how an individual interacts with the social world and, ultimately, how they are treated by members of the dominant group. Figure 1 illustrates the concept of intersectionality as it pertains to race, class, and gender.

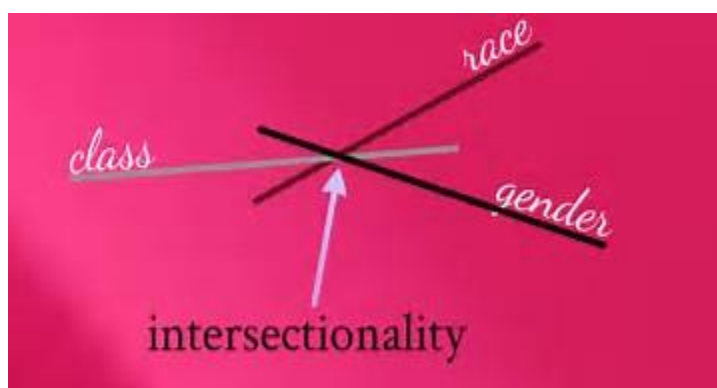


Figure 0.1 Illustration of intersectionality in terms of race, class, and gender

In her critique of society's proclivity to isolate social identities (e.g., treating race and gender as separate and unrelated constructs), Crenshaw (1989, 1991) offered stark examples

from the criminal justice system that elucidate the impact of black women's double jeopardy status in the U.S. For instance, Crenshaw argued that black women experienced sexual harassment in the workplace long before white feminists elevated the issue as a social/employment problem. More recently, through her social activism and legal discourse, Crenshaw has decried the injustice of state-sanctioned violence against women of color in the U.S., which has resulted in the deaths of numerous black females at the hands of law enforcement officers (Crenshaw, Gotanda, Peller, & Kendall, 1995).

To amplify her point, Crenshaw argued that the public is far more familiar with the names of black males killed by police officers (e.g., Michael Brown, Eric Garner, Tamir Rice), as opposed to a number of black women killed by police officers in recent years whose names remain relatively unknown (e.g., Tanisha Anderson, Yvette Smith, Miriam Carey). In view of intersectionality's relevance to social identity, privilege, oppression, and power, Samuels & Ross-Sheriff (2008) opined that "gender cannot be used as a single analytic frame without also exploring how issues of race, migration status, history, and social class . . . come to bear on one's experience as a woman" (p. 5).

Although the standpoint of intersectionality, as articulated by Crenshaw (1989, 1991), was developed under the umbrella of critical race theory (Crenshaw et al., 1995), a review of the extant literature reveals intersectionality theory is an appropriate theoretical framework for guiding and informing public health research (Bauer, 2014; Bowleg, 2012; Rogers & Kelly, 2011). Intersectionality theory has the potential to inform research methodologies designed to uncover health disparities that stem from the long-term effects of systematic racism and discrimination. Arguably, even ageism and age discrimination could be linked to poor health and chronic disease (Allen, 2016). For instance, applying the theory of intersectionality to health

disparities, a black female in her late 50s is more likely to be diagnosed with a chronic health condition than her white counterpart, and will likely encounter barriers to accessing quality healthcare if she has low-income and/or lacks health insurance (Gary et al., 2015). Against this backdrop, the intersectionality perspective was deemed an appropriate theoretical framework to guide the study of low-income black women's experiences with and views toward menopause and aging.

2.1.1 Intersectionality, menopause, & aging

At first blush, intersectionality and menopause make strange bedfellows. As the existing literature reveals, however, race and ethnicity are two intersecting identities shown to be associated with various aspects of the menopause transition (Freeman, Sammel, Grisso, Battistini, Garcia-Espagna, & Hollander, 2001; Palmer, Rosenberg, Wise, Horton, & Adams-Campbell, 2003; Dillaway, 2016). Although some studies conducted in the U.S., including large, population-based studies, have investigated racial/ethnic differences among menopausal women, there is a dearth of research employing intersectionality theory in studies related to reproductive aging. In fact, the Boolean search string, *intersectionality, menopause, and aging* resulted in only one journal article, summarized below.

Using intersectionality as a conceptual lens, Dillaway (2016) conducted a qualitative study involving in-depth interviews of 130 midlife women between the ages of 38 and 65. The sample was comprised of nearly an equal number of black and white participants (i.e., 58 and 60, respectively). In this study, Dillaway explored racial/ethnic differences in women's attitudes toward surgically induced menopause (i.e., hysterectomies). Dillaway found that, in contrast to white women, black participants were wary of doctor's initial recommendations to undergo a

hysterectomy and felt the surgery was unnecessary. Some black participants even expressed concern that doctors were targeting them for unnecessary hysterectomies.

White participants, on the other hand, were not nearly as wary as black women about the prospect of undergoing a hysterectomy, and, in fact, most welcomed the suggestion of having a hysterectomy to be free of menstrual cycles. Based on her interviews with black women, Dillaway (2016) concluded that black women's decision-making process of whether to have a hysterectomy was "potentially influenced by women's racial/ethnic locations and the history of racial/ethnic discrimination against African Americans within U.S. medical institutions" (p. 319). Given the paucity of research investigating menopause and aging using an intersectionality framework, the present study is sorely needed to elucidate low-income black women's menopausal experiences and views toward aging. In preparing to conduct such a study, I performed a thorough review of literature published primarily within the past 10 years.

2.2 Literature Review

2.2.1 Literature search strategy

To date, the earliest and largest empirical research study investigating menstruation and women's health is the Tremin Longitudinal Study, which began in 1934 at the University of Minnesota and is ongoing (Mansfield & Bracken, 2003; Mansfield, Carey, Anderson, Barsom, & Koch, 2004). Based on data collected from over 5,000 participants, this landmark study has made outstanding contributions to the study of women's reproductive health, which includes, most notably, the concept of perimenopause (Mansfield et al., 2004). Over the past 80+ years since the Tremin study launched, researchers have made significant strides in the study of menopause, reflecting a growing interest in women's reproductive health.

To illustrate, an EBSCOhost database search using the term *menopaus**² generated 225,886 results for the period 1870 through 2017. When the same search was limited to include only scholarly, peer-reviewed articles, the EBSCOhost search generated 63,361 results, which still reflects strong empirical interest in the topic. In laying the groundwork for a comprehensive, systematic review of original research studies investigating black women's menopausal experiences, my literature search targeted only scholarly, peer-reviewed articles published from 2006 through 2017. By restricting the time frame to roughly 10 years, the objective was to gather the most current and relevant research findings recently published. It should be noted that I excluded literature reviews, book reviews, and other non-research articles from the results. In October of 2018, while writing Chapter 5, I refreshed my literature search. Figure 2.2 reflects the various EBSCOhost databases accessed in my search of original research studies published within the past 10 years:



Figure 0.2 EBSCOhost databases

² letter “e” dropped and asterisk inserted to capture all forms of the word *menopause*

To locate current articles related to black women's menopausal experiences and perspectives, I executed a Boolean search strategy by inputting a variety of key terms, which generated the results shown in the far right-hand column of Figure 2.3:

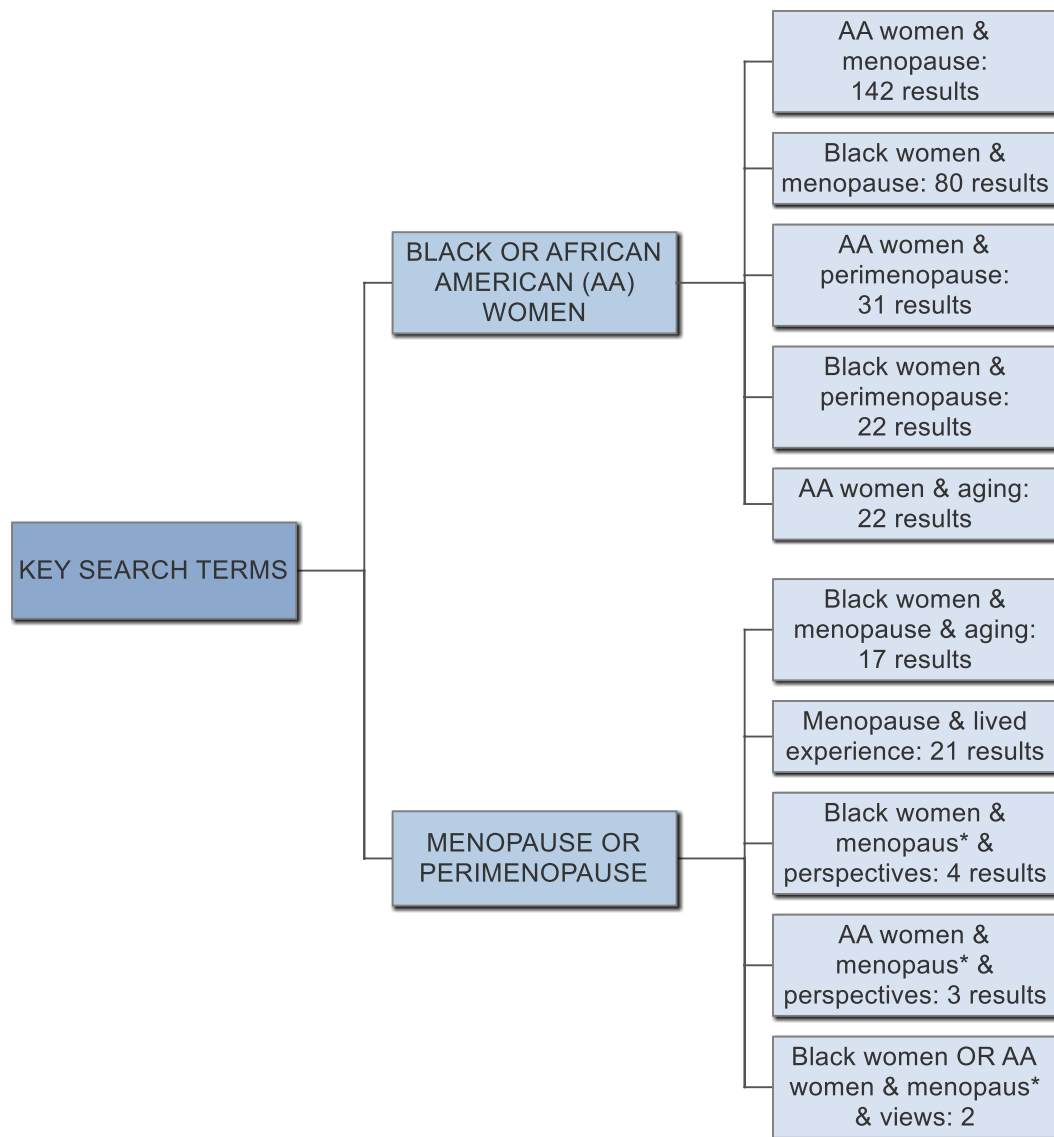


Figure 0.3 Key search terms and results

Of the results generated, only articles reflecting the above search terms in the article's title were included in the review. Results including articles that contained the above search terms but also included other health issues in the title, such as breast cancer or urogenital disorders, were

excluded from the review. It should be noted that the references of original research articles and literature reviews were mined to locate journal articles directly related to the topic.

2.2.2 Menopause terminology & definitions

Menopause, a normal physiologic occurrence in midlife women, is defined as the final menstrual period following 12 months of amenorrhea (The North American Menopause Society, 2017). Although the exact time of menopause varies widely, according to the U. S. Department of Health and Human Services (2010) the average age of menopause typically occurs between 48 and 52 years. The process of reproductive aging is characterized by several distinct stages including menarche (the first menstrual period), reproductive, perimenopause, menopause, and postmenopause (Harlow et al., 2012). Clinically speaking, menopause is caused by the reduction of estrogen and progesterone levels within a woman's ovaries and bloodstream (U.S. National Library of Medicine, 2015). Based on findings from the executive summary of the stages of reproductive workshop of 2011 (STRAW + 10), the stages (adapted) are summarized in Table 2.1 (Harlow et al., 2012).

This space intentionally left blank.

Table 0.1 Stages of Reproductive Aging

Stages	Brief description
Menarche	Onset of first menstrual period
Reproductive	Years marked by regular menstrual cycles
Menopausal transition/perimenopause	Around the time of onset of menopause marked by distinct physiological signs and symptoms (e.g., vasomotor symptoms, menstrual irregularity, vaginal dryness)
Postmenopause	The period marked by cessation of menses for at least 12 months (early: within 1 to 2 years of cessation; late: 3 to 6 years of cessation, and beyond)

For the purposes of this review, the literature examined hereafter focuses primarily on the menopause transition (i.e., early to late perimenopause and early postmenopause), the reproductive stages that typically occur between the ages of 45 and 60. Notably, there has been considerable debate in the literature as to when the menopause transition actually begins in healthy women and how long the process usually lasts (Dillaway, 2006; Mansfield et al., 2004). Additionally, research efforts have sought to differentiate among ovarian, somatic, and chronological aging to better understand the menopause transition (Dillaway, 2006; Harlow et al., 2012). Traditionally, female reproductive aging has been categorized into three broad stages including pre-, peri-, and postmenopause to designate (a) the years before the menopause transition, (b) the stage leading up to the onset of menopause, and (c) the years following the cessation of menses, typically marked by at least 12 months of amenorrhea, respectively (Mansfield et al., 2004).

Based on extensive qualitative research, Dillaway (2006) argued that the existing body of literature on women's reproductive health lacks a clear definition of what menopause is, when it

occurs, how women transition through the various stages, and how long menopause lasts in the average female life span. Dillaway's research findings indicate that women's menopausal experiences can vary widely, and "women can flip-flop between the three stages" (p. 36). She cautions that grouping menopausal women into predetermined, progressive stages, such as pre-, peri-, and postmenopause, is an oversimplification of a very complex and individual process that ultimately has implications for women's healthcare.

2.2.3 Significance of menopause research

According to the National Center for Health Statistics (2016), American women are living longer than ever before, with an average life expectancy of about 81 years. U.S. Census Bureau data show that, in 2006, nearly 40 million women were baby boomers between the ages of 42 and 60, and 27 million women were over the age of 60 (U.S. Census Bureau, 2006). Based on these statistics, it has been estimated that over 40% of the entire female population in the U.S. is currently either perimenopausal or postmenopausal (Newhart, 2013). While a fair amount of population-based studies and other empirical research have been conducted on menopause and the menopausal transition (e.g., the Study of Women's Health Across the Nation [hereafter, the SWAN], the Massachusetts Women's Health Study), the above data suggest that both women's reproductive and midlife health will continue to be of utmost importance to American women.

In view of existing population/health data, it is incumbent upon public health researchers, feminist gerontologists, and others to advance the science of menopause research (Newhart, 2013). Despite the corpus of knowledge amassed thus far, many other aspects of the menopause transition have not been thoroughly investigated, particularly as it relates to women of diverse races/ethnicities (Huffman, Myers, Tingle, & Bond, 2005). To date, what is known about the menopause transition is racially biased, because much of it is predicated on Caucasian, middle-

class norms (Dillaway et al., 2008; Whiteley, DiBonaventura, Wagener, Alvir, & Shaf, 2013) while the experiences and perspectives of minority midlife women are comparatively understudied. In an effort to close the knowledge gap, researchers are beginning to investigate racial/ethnic differences among menopausal women (e.g., Sutton-Tyrell et al., 1995/1996).

2.2.4 Racial/ethnic differences among midlife women

Research conducted over the past decade shows there are statistically significant racial/ethnic differences among menopausal women's experiences. For instance, in a cross-sectional, population-based study of peri- and postmenopausal women, Reed et al. (2013) found that black women self-reported a greater incidence of hot flashes than Caucasian women, while Japanese women reported fewer occurrences of hot flashes relative to other races.

Other studies document similar findings with respect to racial differences and vasomotor symptoms. In a study investigating the incidence of hot flashes in a sample of 613 pre- and perimenopausal women, Miller et al. (2006) found that, among perimenopausal women, black women were more likely than Caucasian women to report having severe hot flashes and hot flashes for more than 5 years. Based on objective measures, black women in the study were found to have higher body mass index (BMI) and lower estrogen levels than Caucasian women, conditions that were correlated with a higher incidence of hot flashes in black women (Miller et al., 2006).

The literature also reports other racial/ethnic differences among menopausal women. For instance, black women are diagnosed with uterine fibroid tumors at a significantly higher rate than their Caucasian counterparts (Jacoby, Fujimoto, Giudice, Kuppermann, & Washington, 2010). Fibroid tumors are the leading cause of hysterectomies in the U.S. (Jacoby, 2010); and because black women carry a heavier burden of contracting fibroid tumors than other races, they

are more likely to undergo surgically induced menopause (Weiss, Noorhasan, Schott, Powell, Randolph, & Johnston, 2009).

In a longitudinal study investigating the growth of uterine fibroid tumors found in pre- and perimenopausal women, Peddada et al. (2008) found significant differences in the growth rates of fibroids tumors among black and Caucasian women. As participants aged, the growth rate of fibroid tumors found in black women showed little decline, whereas the growth rate among aging Caucasian women declined at a much faster rate. Although the sample in this study was relatively small ($N = 72$), findings demonstrate that racial/ethnic differences exist among women at different stages of the menopause transition.

In addition to quantitative research conducted over the past 10 years, several qualitative studies have uncovered racial/ethnic differences in the experiences of menopausal women (Dillaway et al., 2008; Dillaway, 2016; Im et al., 2010; and Nixon et al., 2008). The studies cited found notable differences in participants' attitudes toward menopause and the meanings they assigned to their experiences. Notably, Dillaway, Im, and Nixon based their studies on intersectionality constructs, positing that the biopsychosocial process of menopause is influenced by the social locations of race, ethnicity, and class.

In a study of 61 menopausal women of diverse racial/ethnic and class locations, Dillaway et al. (2008) queried participants about their menopausal signs/symptoms, the impact of menopause on family and work contexts, views on menopause and aging, perceptions of bodily changes, and medical issues. Among the findings, Dillaway and colleagues found that working class women adopted a positive view of menopause, whereas middle-class Caucasian women expressed more negative feelings about menopause. Although all participants expressed feeling frustrated about somatic changes, the consensus of black participants was they lacked the time

and energy to worry about menopause, as they were preoccupied with more serious problems that demanded their attention.

Racial/ethnic differences also were observed in terms of social support. In contrast to Caucasian participants, who reported having fewer close-knit networks in which they could share menopausal experiences, black and Hispanic participants reported having more friendship connections wherein they could share menopausal concerns. In summarizing their findings, Dillaway et al. (2008) concluded, “[W]e must pay more attention to the intricacies of privilege and oppression as they impact women’s health” p. 778.

Applying the intersectionality framework to a more recent study, Dillaway (2016) explored racial/ethnic differences in women’s attitudes toward surgically induced menopause (i.e., hysterectomy). Of 130 menopausal women, 20 participants had undergone a hysterectomy prior to being interviewed, and 33% of the women considered having a hysterectomy based on a physician’s recommendation. Based on this sample of participants, Dillaway found that black participants were significantly more distrustful of undergoing a hysterectomy than Caucasian participants.

In weighing their options, Black women reported being wary about undergoing a hysterectomy, whereas Caucasian women were much more optimistic about the prospect of having a hysterectomy. In some cases, Caucasian participants welcomed the opportunity to have a hysterectomy, as it would result in freedom from menstrual cycles. Dillaway attributed the women’s attitudinal differences to the residual effects of privilege and oppression, as experienced by Caucasians and blacks, respectively. Based on the study’s findings, Dillaway suggested that black women’s fears of racial/ethnic discrimination by medical institutions haunt many black women, and these fears in turn influence their healthcare decision-making.

2.2.5 *The medicalization of menopause*

Menopause is defined as the end of menstruation, a point in time marked by the absence of menses for at least 12 consecutive months (The North American Menopause Association, 2017). The period leading up to menopause, known as perimenopause, is a gradual transition of physiological changes that take place over several years. Although perimenopause is characterized by numerous biomarkers, according to The Boston Women's Health Book Collective (2006), "The only changes that are scientifically recognized as associated with menopause are the end of menstrual bleeding, hot flashes, night sweats, insomnia, and vaginal dryness" (p. 5). Menopause-focused research launched over the past 10 years supports the assertion that menstrual cycle changes, (including menses cessation), vasomotor symptoms, sleep disturbances, and vaginal dryness are prominent hallmarks of the menopause transition (Gold et al., 2006; Miller et al., 2006; and Paramsothy et al., 2014).

Feminist researchers and women's health advocates contend that the menopause transition is a natural process that should not be treated as a disease (Meyer, 2003; The Boston Women's Health Book Collective, 2006). In fact, this is one reason why feminists prefer the terms *signs* and *signals* rather than *symptoms* when referencing the natural, physiological changes associated with the menopause transition (The Boston Women's Health Book Collective, 2006). According to women's health advocates, the term *symptom* carries a negative connotation, whereas the terms *sign* or *signal* are neutral. Akin to how some view the aging process in general, physiological changes related to the menopause transition have been pathologized as if some form of medical intervention is necessary. In the excerpt below, authors of The Boston Women's Health Book Collective (2006) argued that pathologizing menopause is

the wrong approach to addressing women's concerns related to the process of reproductive aging:

Some medical researchers, healthcare providers, and drug companies have defined menopause as a hormone 'deficiency' condition due to ovarian 'failure.' According to this view, menopause is a condition like thyroid deficiency or diabetes: If it is left untreated we will be at greater risk for many chronic diseases, a lower quality of life, and premature death. (p. 8)

While it is true some midlife women seek the advice of a physician regarding menopause related conditions (e.g., hot flashes, night sweats, vaginal dryness, and insomnia), most women experiencing natural menopause are able to cope with the vicissitudes of menopause without medical or pharmacologic intervention, such as hormone replacement therapy (The Boston Women's Health Book Collective, 2006). Although an in-depth discussion of hormone therapy is beyond the scope of this review, suffice it to say, researchers have investigated and continue to research whether hormone therapy can improve the health-related quality of life (HrQoL) of peri- and postmenopausal women (Wachtel, Yang, Dissanaik, & Margenthaler, 2015). Observational studies such as the Women's Health Initiative have investigated whether HRT reduced the risk of coronary heart disease and other chronic illnesses in midlife women (Rossouw, Manson, Kaunitz, & Anderson, 2013).

Recent studies investigating the efficacy of hormone therapy for peri- and postmenopausal women generated mixed findings. For example, Close, Mason, Wilson, & Hungin (2012) conducted a large, retrospective study in the United Kingdom to examine the association between HRT and gastrointestinal problems. Based on a sample of 51,182 menopausal women, Close and colleagues observed a statistically significant relationship

between estrogen therapy and gastro-esophageal reflux disease. In a study examining the association between HRT and breast cancer, Wachtel et al. (2015) found a weak relationship between an increase in HRT prescriptions and the incidence of breast cancer.

Finally, in a prospective study investigating the association between HRT and coronary heart disease, Grodstein et al. (2006) found that women who began HRT in late perimenopause had a 30% lower risk of developing coronary heart disease compared to postmenopausal women who never used hormone therapy. For women in this same study who started HRT at least 10 years following the onset of menopause, however, no statistically significant relationship was found. Based on their findings, Grodstein and colleagues concluded that the risk for developing coronary heart disease in midlife women appears to be connected to the timing of initiating HRT in relation to the onset of menopause. In sum, despite the apparent mixed results concerning the clinical efficacy of HRT, the medicalization of menopause remains an important topic in women's health literature. Thinking more broadly, no matter which reproductive stage of aging women are in, quality of life is a more practical and overarching concern for many midlife women.

2.2.6 Menopause & health-related quality of life (HRQoL)

American women's current average life expectancy coupled with the average age of menopause means that most women who remain healthy can expect to live approximately 30 years postmenopause. Factoring in the menopause transition, the stages of reproductive aging can conceivably take place over the course of 40 years, nearly half a woman's lifespan or longer, depending on how long she lives. Because menopause affects women across different dimensions (i.e., physiologically, psychologically, emotionally, and relationally), health-related

quality of life (HRQoL) issues have captured the attention of menopause researchers for at least the past 10 years.

Cross-sectional and longitudinal studies have been conducted to examine the impact of menopause on women's HRQoL. For instance, in a longitudinal study, Hess et al. (2012) recruited a sizable sample of 732 women between the ages of 40 and 65 from a general medical practice. The researchers investigated the impact of menopause status on women's HRQoL, notwithstanding menopausal symptoms. Hess and colleagues hypothesized that HRQoL would decline in early perimenopause and improve in late postmenopause as women adapt to a new phase of life.

Contrary to expectations, the researchers found that after 5-year follow-up postmenopausal women, as well as women who had undergone a hysterectomy, endorsed lower HRQoL compared to women in early perimenopause³. In this sample, lower HRQoL was reflected in overall physical health, with pain and fatigue symptoms emerging as salient. In addition to measures of physical health, Hess and colleagues also examined mental health and social support variables. Lower mental and emotional wellbeing were most prominent in late peri- and early postmenopause and attenuated in late postmenopause. These findings suggest perimenopause can have a negative impact on HRQoL including physical, mental, and emotional dimensions.

Using the SWAN data, Avis, Assmann, Kravitz, Ganz, & Ory (2004) investigated the association between menopause status and global quality of life among women aged 40 to 55 and considered race and ethnicity. The SWAN is an ongoing population-based investigation of 13,874 midlife women across the U.S., including women from various races/ethnicities (i.e.,

³ Based on the physical health composite of the RAND-36, results reflected scores of .09 for women in early perimenopause, .21 for women in late postmenopause, and .23 for women who had hysterectomies ($P < .01$).

Caucasian, African American, Hispanic, Chinese, and Japanese [Sutton-Tyrell, 1996/1997]).

Global quality of life was assessed by physical symptoms (e.g., trouble sleeping, headache, heart pounding), lifestyle factors (e.g., BMI, smoking), attitudes toward menopause, and social support.

Based on unadjusted analyses, Avis et al. (2004) found that, across each racial/ethnic group, women in early perimenopause reported the lowest quality of life, findings that are consistent with results reported by Hess et al. (2012). When variables such as marital status, perceived stress, education, and social support were factored into the analysis, the association between menopausal status and quality of life attenuated. In terms of racial/ethnic differences, a number of similarities and differences were noted in relation to menopause status and quality of life. For example, African American women in postmenopause, including those who had undergone a hysterectomy, endorsed higher quality of life. By contrast, Japanese women endorsed higher quality of life in late perimenopause. Hispanic women who had undergone a hysterectomy reported lower quality of life compared to premenopausal women.

Across all racial/ethnic groups, married women who reported less stress endorsed higher quality of life. Perceived stress was highest among women in early perimenopause and highly related to overall quality of life. A principal take-away from the study is that, in unadjusted analyses, menopause status appeared to be associated with quality of life. Multivariable regression analyses painted a different picture, however, resulting in the finding that perimenopause was not significantly associated with quality of life for any racial/ethnic group. Results from this study indicate that more research on racial/ethnic differences among midlife women should be conducted using large, population-based studies.

A study conducted by Whiteley et al. (2013) took a slightly different approach to examining menopause and HRQoL issues. In their investigation of menopausal symptoms on HRQoL, Whiteley and colleagues also examined the effect of menopausal symptoms on women's employment, healthcare utilization, and daily activities. To determine the impact of menopause symptoms on the aforementioned variables, the researchers analyzed data from the 2005 U.S. National Health and Wellness Survey, a population-based study comprising 8,811 women between the ages of 40 and 64. The sample was divided between women who reported menopausal symptoms and those who did not.

After adjusting for demographic and health characteristic differences, Whiteley and colleagues found that women who reported menopausal symptoms experienced lower physical and mental HRQoL, compared to those who reported no menopausal symptoms⁴. Among employed women, participants who had severe menopausal symptoms reported higher overall work impairment than women who reported no menopausal symptoms⁵. Additionally, participants who experienced menopausal symptoms reported significantly higher levels of impairment in daily activities and more recent doctor visits than nonmenopausal women.

The most commonly reported menopausal symptoms included hot flashes, night sweats, sleep disturbances, mood changes, and decreased interest in sex. Night sweats and depressive symptoms most frequently were associated with an increased number of emergency room visits. Based on their findings, Whiteley and colleagues determined that menopausal symptoms significantly impact midlife women's HRQoL, work productivity, and daily activities. The authors further concluded that, depending on the severity of symptoms, menopause can exact a

⁴ Physical HRQoL: 46.8% vs. 48.6%, $p<.05$; Mental HRQoL: 45.8% vs. 47.4%, $p<.05$

⁵ Work impairment: 16.1% vs. 12.3%, $p<.05$; Absenteeism: 3.7% vs. 3.4%, $p=.50$

heavy economic toll that translates into lost wages and higher medical costs for women in midlife.

2.2.7 Black women & menopause

Research conducted over the past 10 years has shed light on important issues concerning the menopause transition such as HRQoL, hormone therapy, surgically induced menopause, and racial/ethnic differences in the perimenopause experience. While several U.S. population-based and prospective studies have made strides to increase sample diversity (e.g., the SWAN), smaller cross-sectional studies are still employing racially biased samples, such as the Whiteley et al. (2013) investigation, in which most participants were Caucasian (i.e., 89%). A careful review of the literature further reveals that the lived experiences and perspectives of black menopausal women remain significantly underexplored. The experiences and views of low-income black menopausal women have received even less attention in the literature.

This research deficit may be due to both challenges and barriers related to recruiting African Americans in general, which is believed to stem from issues of distrust of doctors and medical institutions (Coker, Huang, & Kashubeck-West, 2009; Hughes et al., 2015; Washington, 2006). Unfortunately, vestiges of the Tuskegee Syphilis Study and other medical research misconduct continue to haunt the collective psyche of African Americans (Katz, Green, Kressin, James, Wang, Claudio, & Russell, 2009). Another example of unethical conduct in medical research that bears mentioning is the story of Henrietta Lacks, an African American woman who died of metastatic cervical cancer in 1951 (Skloot, 2010). Without Lacks' knowledge and consent, medical researchers at Johns Hopkins harvested her cancer cells and genome for biomedical research, resulting in phenomenal scientific breakthroughs that are still in use today. Not only did medical researchers obtain Lacks' cancer cells without her consent, but years after

her death, biomedical researchers obtained blood samples from her offspring without their informed consent. These and many other historical examples of the maltreatment of African Americans in biomedical research and experimentation have resulted in significant recruitment challenges that persist to this day. Despite ongoing recruitment challenges, researchers should attempt to overcome sociocultural barriers in accessing minority populations to expand the scientific knowledge base of the elusive menopause transition.

The result of a recent literature search for studies related to black women and menopause generated few articles, suggesting a dearth of research focused exclusively on black women's menopausal experiences. Notwithstanding the paucity of research, two qualitative studies (Im et al., 2010; Nixon et al., 2001) and one quantitative study (Li, Rosenberg, Wise, Boggs, LaValley, & Palmer, 2013) examining black menopausal women bear mentioning. Based on longitudinal data obtained from the Black Women's Health Study, Li et al. (2013) investigated the relationship between age at natural menopause and causes of mortality in a sample of 11,212 black women. Participants self-reported reproductive, gynecologic, and other medical data. Researchers extracted mortality data from the National Death Index.

In this prospective study, Li et al. (2013) hypothesized that the onset of natural menopause prior to age 40 is a predictor of accelerated somatic aging in black women. Based on complex statistical analyses⁶, the researchers' hypothesis was confirmed. For this population-based sample, results showed a direct correlation between natural menopause before age 40 and increased mortality risks for chronic illnesses such as heart disease, cancer, and other causes,

⁶ (e.g., mortality rate ratios (MRR), Cox proportional hazards regression analysis, Anderson-Gill, and multivariate models)

which ultimately led to death⁷. These findings lend support to the theory that early menopause in black women is associated with accelerated aging and higher mortality rates.

Turning to qualitative research, Im et al. (2010) explored the experiences of midlife black women by launching an online forum in which researchers solicited the views of 20 black women over a 6-month period. Undergirded by a black feminist conceptual framework, the purpose of the study was to elucidate the experiences of a small sample of black menopausal women, most of whom were college educated and employed. According to the authors, “[T]he feminist perspective maintains that the disease model of menopausal symptoms has been used to gain social control over women, power, and profits for more than 150 years” (Im et al., 2010, p. 436).

Leveraging the power of social media, Im and colleagues identified several qualitative themes including: reliance on inner strength, accepting menopause as a natural part of aging, and lacking knowledge about menopause. The overarching theme was black women’s ability to tap into inner strength to cope with menopausal symptoms, while simultaneously making themselves psychologically and emotionally available to address other demands associated with living as marginalized women. Findings suggest that for many black women, menopause is just another life event, amid many vicissitudes of daily life, that call upon inner strength and resiliency in the face of adverse circumstances, such as racial discrimination. Findings also signal the need for healthcare providers to disseminate timely and accurate information about menopause to educate and prepare black women for this critical life stage (Im et al., 2010).

The strong black woman (SBW) theme was echoed in an older qualitative study that described ways in which a sample of 44 black, rural, low-income women interpreted and coped

⁷ Cancer mortality: MMR = 1.23, cardiovascular mortality: MMR = 1.28, and other-cause mortality: MMR = 1.46, all based on a confidence interval (CI) of 95%

with their menopausal experiences (Nixon et al., 2001). Among other lines of inquiry, interview topics included participants' knowledge and understanding of menopause, biopsychosocial changes associated with the menopause transition, and managing menopausal symptoms. The study's conceptual framework was built on elements of intersectionality theory, (i.e., the reality that racism, sexism, and classism shape the lived experiences of black women). Participants revealed several strategies to cope with menopausal changes including "staying strong, turning inward, enduring, fighting it, praying, and turning to outside resources," such as family, friends, and healthcare providers (pp. 86 – 90).

The most salient theme in the Nixon et al. study was that participants were determined to stay strong in the face of menopausal changes. To cope with the menopause transition, participants employed both internal and external resources such as enduring, praying, and turning to formal and informal systems of support. Qualitative findings from this and the previous study indicate that black women rely on inner reserves (i.e., faith and prayer), as well as social supports and healthcare providers to manage the menopause transition.

2.2.8 Strengths & limitations of existing research

A comprehensive review of the extant literature uncovers both empirical strengths and limitations. In terms of strengths, several longitudinal, population-based studies shed light on the menopause transition (e.g., the SWAN, Seattle Midlife Women's Health Study, Massachusetts Women's Health Study, Women's Health Initiative, and the Black Women's Health Study). These studies are notable for their large, diverse samples, as well as their ability to examine racial/ethnic differences among midlife women. The most glaring limitations of the current body of literature are: (a) a lack of sampling diversity; (b) a lack of qualitative research that focuses exclusively on the lived experiences of minority menopausal women; and (c) an absence of

phenomenological research targeting low-income black menopausal women. Even more noticeable is the paucity of research targeting low-income black women's experiences, due, at least in part, to African Americans' distrust of scientific research and medical institutions.

The present study addresses the literature gap by exploring the lived experiences of a small sample of low-income black women in perimenopause from the southeastern U.S., notably, a geographical area overlooked by the SWAN and other prospective studies. Although other qualitative studies have explored the experiences of black menopausal women over the past 10 years (e.g., Dillaway, 2006; Dillaway, 2016; Dillaway et al., 2008; Huffman et al., 2005; Im et al., 2010), this study employed a phenomenological approach to examining the lived experiences and perspectives of low-income black women in perimenopause. The only qualitative study I found that addressed the menopause transition of low-income black women was conducted by Nixon et al. (2001), published more than 15 years ago. Nixon and colleagues focused on the experiences of African American women from a small rural town in a large eastern state; whereas, the present study targeted low-income black perimenopausal women residing in a large, metropolitan area in the southeastern U.S.

In terms of context, geography in social science research is important to note, as it may give rise to differences in racial/ethnic population density, culture, SES, religious beliefs, and health status, for instance. The southeast region was an ideal research setting for the present study because, according to the U.S. Census Bureau (2011), 55% of African Americans reside in the south. In terms of household income, many African Americans live at or below the poverty level (U.S. Census Bureau, 1999).

2.2.9 Summary & conclusion

As the population of midlife women burgeons in the U.S., researchers investigating the process of reproductive aging are expanding their efforts to elucidate racial/ethnic differences in the menopause transition (e.g., the SWAN study). Despite increasing empirical interest in perimenopause and health-related concerns, black women's experiences and perspectives continue to be overlooked. Because black women's lived experiences are influenced by social identities such as race, gender, and class, intersectionality theory is deemed a relevant theoretical framework for examining black women's menopausal experiences, as well as their views toward aging in general.

The literature reviewed in this chapter revealed there are notable differences in the experiences of black women in perimenopause compared to other races/ethnicities. For example, studies show black women report more vasomotor symptoms such as hot flashes than other groups of women (Gold et al., 2006). In addition, black women carry a heavier burden of fibroid tumors and are more likely to undergo surgical menopause than their white counterparts (Jacoby et al., 2010). Moreover, evidence suggests black women who experience menopause prior to age 40 may be more susceptible to premature aging and death (Li et al., 2013). The present literature review further revealed a paucity of phenomenological research focusing on the experiences and perspectives of black midlife women. To address the literature gap, this study aimed to explore black women's perimenopausal experiences including their knowledge and understanding of menopause, symptom management, attitudes toward menopause and aging, and communication with healthcare providers.

CHAPTER 3 METHODS

3.1 Introduction

This chapter sets forth the research design and methods used to examine low-income black women's perimenopausal experiences. Undergirded by the theoretical framework of intersectionality (Crenshaw, 1989, 1991), the aim of this research was to explore the lived experiences of women who are perimenopausal and to capture the meanings participants ascribed to their experiences. The main research question was: How do low-income black women in midlife perceive and manage the menopause transition? A secondary question was: How do low-income black women understand and interpret their perimenopausal experiences within the larger context of aging?

In phenomenological research, a central question that researchers grapple with is: "What is the nature of the phenomenon as meaningfully experienced?" (van Manen, 1990/1997, p. 40). Thus, a typical phenomenological inquiry is, what is it like to experience thus and so? This type of question is open and expansive enough to encourage participants to talk freely as they tell their stories in their own way and in their own words (Smith, Flowers, & Larkin, 2009). It is important to note that research questions should not be confused or conflated with interview questions. Interview questions are answered by participants, while the research questions are addressed by the researcher (Smith et al., 2009).

3.2 Research design & rationale

On a fundamental level, phenomenological research is the study of phenomena (i.e., things, events, people, or processes). In relation to human activity, phenomenological research is further described as the essence of lived experience as conveyed by the person who is actually having the experience (van Manen, 1990/1997). Phenomenological research necessitates a

mindful or reflexive thought process on the part of the researcher to examine, understand, and interpret lived experience (Etherington, 2004). Polkinghorne (1989) argued that phenomenologists are charged with the task of understanding a subject matter within a particular sociocultural context. Thus, the study of lived experience is an exercise in futility if no reflexive or contemplative thought is given to understanding and interpreting the meaning of lived experience within its sociocultural context.

This investigation used an interpretative phenomenological analysis (IPA) approach (Smith et al., 2009), which is informed by the philosophical perspectives of Heidegger (1962, as cited in van Manen, 1990/1997), Gadamer (1975/2004), and others. Heidegger promoted the concept of *Dasein*, which suggests intentionality in cultivating an awareness or consciousness of being and existence. In *Truth and Method*, Gadamer (1975/2004) extended Heidegger's proposition, adding that an authentic hermeneutic or interpretative understanding of lived experience necessitates an unveiling of the nature of human understanding itself. Predicated on these philosophical underpinnings, IPA was deemed a fitting research tool for exploring the lived experiences of low-income, black women in perimenopause. As a methodology, IPA is aimed at garnering an in-depth understanding of how participants view, interpret, and make sense of their experiences. In the process of data analysis, IPA encourages the use of reflexivity and interpretation on the part of the researcher to make sense of the phenomenon under study.

3.3 IRB Approval

3.3.1 Measures for ethical protection

On November 1, 2017, the Institutional Review Board (IRB) of Georgia State University reviewed and approved the present study. To protect participants from harm and to ensure confidentiality, the conduct of this study was guided by federal regulations and policies set forth

by the IRB. As part of the recruitment process, I conducted a suitability screening with prospective participants to determine eligibility for study participation. As shown in Appendix B, the screening tool is a brief checklist designed to assess whether participants met inclusion criteria (i.e., age, menopause status, and income).

As part of informed consent, participants were advised they would be exposed to no more risk than they would ordinarily experience in daily life. Because the study was phenomenological in nature, which entails self-disclosure of personal and potentially sensitive health information, I anticipated participants might experience a range of emotions in reflecting on their experiences (e.g., joy, sadness, grief, or mild discomfort). To minimize the risk of harm, I was prepared to terminate questioning in the event a participant became emotionally distraught.

As a student researcher, I believe the benefits of participating in research outweigh the minimal risks involved. In planning this study, I anticipated that the benefits to participants would include increased awareness of perimenopause, personal growth, and gaining a fresh and hopefully positive perspective on the aging process. Based on the study's results, as detailed in Chapter 4, I concluded participants were not harmed by the study. In fact, by participating the women acknowledged gaining a better understanding of the menopause transition. In terms of societal benefits, this study contributes to an empirical understanding of how an understudied population perceives and manages the menopause transition. Disseminating study findings to the participants and the larger community, through presentations, for example, helps researchers build trust and sets the stage for future social science research in diverse communities.

3.3.2 Informed consent

Based on IRB guidelines, which can be found at <http://ursa.research.gsu.edu/human-subjects/>, prospective participants who expressed interest in the study and met eligibility criteria

were presented with an informed consent form (Appendix C) at the time of the scheduled interview. The purpose of informed consent was to ensure participants understood the nature and scope of the study, so they could knowledgeably and voluntarily decide whether to participate. As part of the informed consent process, I presented the consent form to each participant and explained the purpose and objectives of the research, as well as the extent of their involvement.

Given that informed consent is an ongoing process, I ensured participants understood that their involvement in the study was completely voluntary and they could withdraw from the study at any time, without penalty. Each participant was encouraged to ask questions about the study and what was expected of her. After participants indicated they understood the research process and verbally agreed to participate, I asked them to sign two copies of the consent form and provided each woman with a signed form to keep for her records.

3.3.3 Confidentiality & anonymity

To protect participants' privacy, confidentiality, and anonymity, I complied with all IRB guidelines and policies set forth by Georgia State University. For example, I ensured participants' personally identifying information (PII), such as full names and contact information remained secure and confidential. Throughout the research process, including writing and reporting the study's results, each participant was assigned a pseudonym in lieu of using their actual names.

Future publications of my thesis will exclude any PII that could identify participants. Furthermore, I will continue to protect all research materials and raw data in the form of digital recordings and other electronic sources, handwritten notes, transcripts, and memos by storing them in a locked file cabinet in my home office. All research materials and raw data as described

herein will be secured for 5 years from the date of IRB approval. Afterward, all research materials and data will be destroyed by file deletion and shredding.

In sum, this study employed an IPA approach to examining and understanding the lived experiences of eight low-income black women in perimenopause. This research is significant because it is an investigation of a demographic that has received scant attention in both the menopause and qualitative literatures. I anticipate findings from the study will broaden and deepen researchers' understanding of the lived experiences of low-income black women navigating the vicissitudes of perimenopause and aging. In addition to addressing a significant gap in the literature, it is hoped my findings and conclusions will give voice to an understudied and underserved population. Moreover, I expect study findings to inform women's healthcare, as well as the fields of professional counseling, public health, and feminist gerontology.

3.4 Recruitment Strategy

The IPA method is an in-depth qualitative approach to studying lived experience (Smith et al., 2009). It is a commonly used method for ethnographic and case study research. Because of its in-depth phenomenological approach, IPA is also recommended for other types of qualitative methods such as focus groups (Creswell, 2007). In IPA research, the objective is quality rather than quantity to garner a deeper understanding of lived experience. For a student research project using IPA, Smith et al. (2009) advised that a sample of "between three and six participants" (p. 51) is reasonable. A small sample size also makes sense from a practical standpoint. Limited resources such as funds, time, and personnel make using smaller samples more appropriate for a graduate research study.

For this study, I employed non-probability and purposive sampling techniques that included convenience and snowball sampling, both of which are typically used in qualitative

research (Creswell, 2007). Convenience sampling is a technique that involves selecting participants based on ease of access. The researcher invites participants to join the study based on their accessibility and proximity. In snowball sampling, participants with lived experience are identified through referrals of existing participants (Ulin, Robinson, & Tolley, 2005).

The main advantage of nonprobability sampling techniques is they are an easy and cost-effective method of gaining access to participants that are close at hand. In terms of disadvantages, nonprobability sampling techniques may result in sampling bias, meaning the sample is not representative of the larger population from which participants are selected (Babbie, 2007). Because generalization is not the goal of phenomenological research, the lack of representativeness is not deemed a drawback in this study.

3.4.1 Inclusion criteria

Perimenopause refers to the span of years preceding natural menopause and includes the 12 months following a woman's final menstrual period (The North American Menopause Society, 2015). In some instances, perimenopause can begin as early as the late thirties, and, for a fraction of women, the onset of natural menopause can occur as late as age 60 or older (The North American Menopause Society, 2015). For the majority of U.S women, however, the typical age range of perimenopause is from 40 to 55 years, with the average age of onset at natural menopause being age 52 (The Boston Women's Health Book Collective, 2006; The North American Menopause Society, 2017).

In a study using data from the Black Women's Health Study (Rosenberg, Adams-Campbell, & Palmer, 1995), a large, follow-up study initiated in 1995, Palmer et al. (2003) observed that the median age at natural menopause in a subsample of 1,323 black women was 48. Based on the literature, I recruited women who were between the ages of 45 and 58, and who

reported perimenopausal symptoms (e.g., hot flashes, missed cycles). In addition to the above inclusion criteria, women who self-identified as black or African American and are English literate were screened for study participation. To assess whether a prospective participant met the low-income criteria, I used the 2017 poverty guidelines set forth by the U.S. Department of Health and Human Services (DHHS) website (U.S. Department of Health and Human Services, 2017).

To illustrate, the poverty guideline for a household of one person is \$12,060. The poverty guideline for a family of two is \$16,240, and so on. It is important to note that the poverty guidelines issued by the DHHS are used to determine financial eligibility for certain federal entitlement programs. Thus, a prospective participant who received benefits from any public assistance program (e.g., Supplemental Nutrition Assistance Program, Medicaid, the low-income home energy assistance program, or Section 8 housing) was deemed to meet the study's low-income criteria.

3.4.2 Screening & eligibility

To obtain the desired sample size, I placed and posted flyers (Appendix A) in numerous public libraries, community health agencies, and recreation centers in Atlanta, Georgia. More specifically, I targeted communities in South Fulton County, because these areas contain large populations of African Americans, many of whom are economically disadvantaged. I also reached out to gatekeepers of social service organizations that offer services and support to women raising grandchildren. As mentioned, inclusion parameters for study participation were age (i.e., 45 to 58), having had a menstrual cycle within the past 12 months, and low-income status, based on self-reporting and federal poverty guidelines. Women who reported having had a hysterectomy were automatically excluded from study participation.

From mid-January through early May, 2018, a total of 23 women telephoned to express interest in the study. Among the 23 women who inquired, eight were screened and deemed eligible to participate based on self-reported information. Through snowball sampling, three participants were referred to the study by women who had been previously interviewed. Women who did not meet inclusion criteria were screened out because they were postmenopausal, reported having had a hysterectomy, or did not meet the low-income threshold.

3.4.3 Sample characteristics

The total sample in the study comprised eight women who met inclusion criteria. To protect the women's identity, I assigned each participant a first-name pseudonym. Pertinent demographic characteristics are displayed in Tables 3.1 through 3.3. Note age of menarche in Table 3.1 refers to the self-reported age at which each participant's first menstrual cycle began.

This space intentionally left blank.

Table 0.1 Personal Demographic Variables

Participants	Age of Menarche	Age at Interview	Self-rated Health
Annette	13	57	Fair
Betty	14	57	Fair
Carla	12	56	Fair
Deborah	13	55	Very good
Ellen	18	49	Good
Felicia	13	55	Good
Grace	10	49	Good
Henrietta	14	50	Very good

Note: Mean participant age is 53.5 years. Mean age at menarche is 13.4 years.

Table 0.2 SES Variables

Participants	Marital Status	Education	Annual Income	Public Assistance
Annette	Divorced	High school	8,100.00	Medicaid, Food Stamps
Betty	Widowed	3-4 years of college	7,000.00	Medicaid, Food Stamps
Carla	Single	5-6 years of college	6,000.00	Medicaid, Food Stamps
Deborah	Single	High school	8,856.00	Medicaid, Food Stamps
Ellen	Single	High school	8,184.00	Medicaid, Food Stamps
Felicia	Single	High school	Unemployed	Food Stamps
Grace	Single	1-2 years of college	16,000.00	None
Henrietta	Married	1-2 years of college	9,600.00	None

Note: Mean income is \$9,106

This space intentionally left blank.

Table 0.3 Participant Health Characteristics

Participants	Perimenopausal Signs & Symptoms	Chronic Health Conditions
Annette	Mood swings, night sweats, depressive symptoms, weight gain, hot/cold spells, memory changes	Arthritis
Betty	Insomnia, depression, hot flashes, hot/cold spells, thinning hair, cramping, memory changes	Diabetes
Carla	Depression, heavy bleeding/blood clots, protracted periods, irritability, memory changes, hot/cold spells, memory changes	Chronic pain, undiagnosed
Deborah	Hot flashes, night sweats, protracted periods, night sweats, mood swings, appetite changes, depressive symptoms, memory changes	Hypertension
Ellen	Night sweats, hot flashes, bouts of insomnia, depressive symptoms, difficulty concentrating, easily distracted	Fibromyalgia, endometriosis, fibroid tumors, hypertension
Felicia	Hot flashes, hot/cold spells, mood swings, irritability, insomnia, memory changes	Hypertension, high cholesterol
Grace	Weight gain, insomnia, early morning wakening, mood swings, irritability, emotionally sensitive, irregular cycles	Hypertension
Henrietta	Hot flashes, mood swings, heavy bleeding, severe cramping, insomnia, memory problems	None reported

As shown in Table 3.3, participants reported various signs and symptoms typically associated with the menopause transition (e.g., hot flashes, night sweats, mood lability). Additionally, seven participants self-reported having at least one chronic health condition such as hypertension, high cholesterol, and diabetes. Thus, in addition to managing perimenopausal symptoms, seven participants also managed a chronic disease.

3.5 Data Collection

For this study, I constructed three data collection instruments to obtain personal information from participants: a screening questionnaire (Appendix B), a demographic questionnaire (Appendix C), and the interview schedule (Appendix E). To determine eligibility for participation, I used a 17-item screening questionnaire containing questions such as: What is

your total household income? What is the month/year of your last menstrual period? Have you ever had a hysterectomy? Tell me about the signs and symptoms you are currently experiencing that lead you to believe you are going through the change?

As prospective participants were deemed eligible, I scheduled interviews based on the women's convenience at local public libraries. I conducted all eight interviews at two different library branches in South Fulton County; six interviews were conducted at one branch and two at another location. At the outset of each interview, I used the demographic questionnaire (Appendix C) to collect information from participants such as age, race, education, employment status, marital status, and religious affiliation.

Prior to asking interview questions, I gave each participant ample time to carefully read and sign the consent form (Appendix D). As part of the informed consent process, I reminded participants that their participation in the study was voluntary, and any information disclosed would be treated as confidential. After inspecting and signing the consent form, none of the participants had questions about the research study. Finally, I provided each participant with an original/signed copy of the consent form to review and keep for her records. For my records, I maintained an original/signed copy of all consent forms.

3.5.1 Interview process

To generate rich and descriptive data (Geertz, 1973), I organized numerous interview questions under the following categories: general health status, menstruation history, perimenopausal signs and symptoms, perceptions and attitudes toward menopause and aging, communications and interactions with medical professionals, healthcare challenges, quality of life, and the impact of perimenopause on intimate and interpersonal relationships. As shown in Appendix E, the interview schedule consisted of mostly open-ended questions such as: Tell me

about any physical changes, signs, or symptoms you have recently experienced with your menstrual cycle; and, in general, how have you felt about menstruation throughout the years? As the participants' narratives unfolded, additional questions arose organically throughout the interview process (e.g., Do you feel you've lost a sense of purpose? Have other people said anything to you about your mood swings?).

Because this study was developed using an intersectionality framework, I formulated a few questions to address issues of race, gender, class, and age. Examples of interview questions designed to elicit intersectionality discourse were as follows:

- What thoughts do you have about being a black woman in midlife?
- In your opinion, how are black women's change-of-life experiences similar or different from women of other races/ethnicities?
- In general, how do you feel about getting older, and what meaning does it have for you?

Increasingly, researchers are employing the perspective of intersectionality to examine the lived experiences of minority and disadvantaged populations, as this framework attends to social realities and identities in ways that conventional conceptual frameworks fall short (e.g., Bauer, 2014; Bowleg, 2012; Harnois, 2014). Theoretical implications of using intersectionality as a conceptual framework are discussed in Chapter 5.

At the end of each interview, I thanked the participants for their time and gave each woman \$25 in cash as a token of my appreciation. Interview lengths ranged from 35 to 79 minutes ($M=59.5$ minutes). To refresh my memory, I prepared a memorandum to reflect on the dyadic encounter, to capture thoughts and feelings about the interview, and to document my perceptions of each participant (see Appendix H for sample interview memo).

For transcription purposes, I employed TranscribeMe, Inc., a company that provides transcription services electronically via the NVivo™ software platform. A TranscribeMe representative reviewed and signed a confidentiality form (Appendix F) prior to their transcribers receiving and transcribing audio content. To ensure accuracy and completeness, I reviewed and edited each transcript in its entirety while listening to the audio recordings. All transcripts were transcribed verbatim. The process of reviewing/editing the transcripts constituted the beginning of data analysis.

3.6 Data Analysis

IPA is an iterative, inductive process that starts with reading each transcript several times to immerse oneself in the data. To gain familiarity with participants' narratives, I performed a line-by-line analysis of each transcript, which involved making annotations to note my observations (see Appendix G for sample transcript excerpt). In my perusal of each transcript, I closely examined each participant's narrative as a whole, in parts, and in relation to other participant accounts to move toward concept and theme development (Smith et al., 2008; Smith & Osborn, 2008).

To review, store, manage, and analyze the raw data, I utilized NVivo™ (version 12), a qualitative software program by QSR International. Using NVivo™ coding techniques, I identified salient patterns and themes in the data. I also used NVivo™ to create illustrations and diagrams representing recurrent themes and relationships between themes (e.g., see Figure 3.1). Finally, I used NVivo™ to capture quotations reflecting the essence of participant accounts (Smith et al., 2008; Smith & Osborn, 2008).

Throughout the process of identifying recurrent themes, I drew connections between concepts that related to each other to make sense of the data. In doing so, I clustered together any

related concepts to develop an overarching theme or construct (Smith & Osborn, 2008). Figure 3.1, for instance, illustrates concept clusters developed in first-cycle coding that stemmed from the node, perimenopause stage:

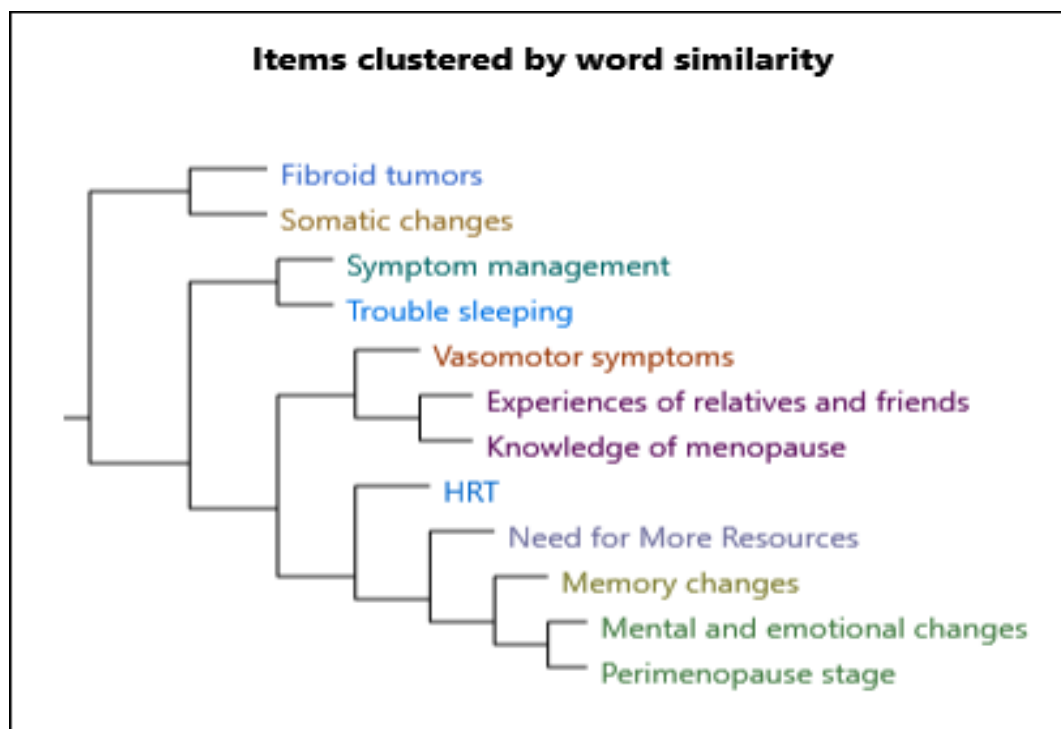


Figure 0.1 NVivo illustration of concept clusters identified in second-cycle coding

Next, I checked the concept clusters against the transcripts to ensure they were congruent with participants' words and assigned meanings. For instance, the concept, need for more resources, was corroborated by the following statements: "I would like further information to read up on (Annette, age 57); and, I don't know what all come with it, so I probably don't have all the resources I need" (Felicia, age 55). It should be noted that NVivo™ proved to be an excellent tool to facilitate theme development including coding, clustering, and aggregating emergent themes and concepts. In a description of the IPA process, Smith and Osborn (2008) offered, "As a researcher, one is drawing on one's interpretative resources to make sense of what the person is saying, but at the same time is constantly checking one's own sense-making against what the person actually said" (p. 72).

Smith et al. (2009) detailed a six-step analytic process in IPA. These steps are listed as follows: 1) Reading and re-reading, 2) Initial noting, 3) Developing emergent themes, 4) Searching for connections across emergent themes, 5) Moving to the next case, and 6) Looking for patterns across cases. Smith and colleagues emphasized the steps provide a procedural approach to the IPA method, but the authors suggested there is no prescribed single method for IPA data analysis. The IPA data analysis strategy used in this study is illustrated in Figure 3.2:

IPA Data Analysis Strategy

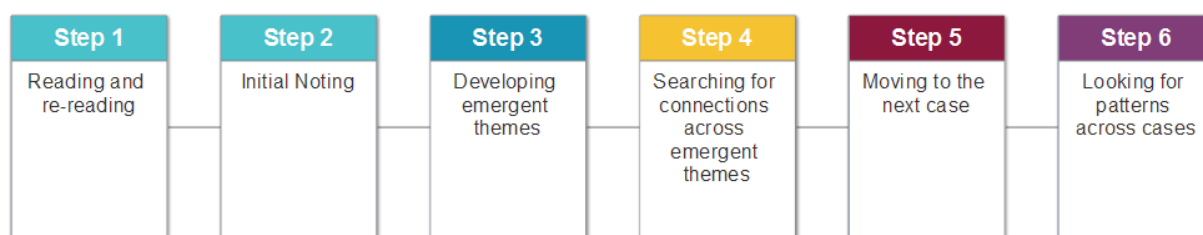


Figure 0.2 IPA six-step strategy used in data analysis

Smith et al. (2009) proposed IPA is flexible enough to allow qualitative researchers to tailor the suggested six-step procedure to fit the researcher's strategy of analyzing and making sense of the data. The authors maintained, "There is no clear right or wrong way of conducting this sort of analysis, and we encourage IPA researchers to be innovative in the ways that they approach it" (p. 80). Because I used NVivo™ to store, categorize, code, and explore the raw data, the IPA method was adapted to fit an electronic versus a hard-copy coding process. Due to NVivo's large data management capacity, I was able to perform steps three through six simultaneously to identify and develop patterns and emergent themes within and across all eight cases.

Accordingly, step one, reading and re-reading the data, allowed me to immerse myself in the data, not only for familiarity, but also to actively engage with the data. In so doing, I read and

reviewed each transcript while listening to each audio recording multiple times. In step two, initial noting, I performed a line-by-line analysis of each transcript and inserted observational and exploratory comments in the right-hand margin of each transcript. Several examples of my initial transcript noting are bulleted below:

- This participant has a very negative view of healthcare professionals.
- This participant reports being disconnected from family. Is she depressed because birthdays remind her she is getting older, or is it due to the lack of family support, or both?
- Patient-doctor communication problems is a recurring theme for this participant.
- Sounds like the fibromyalgia, fibroid tumors, and endometriosis have loomed larger for this participant than perimenopause.

Steps three through six were performed simultaneously in an iterative and inductive fashion to identify patterns and emergent themes within and across cases (i.e., transcript files). To facilitate thematic development, I performed three distinct coding cycles in NVivo: initial coding, second-cycle coding, and thematic coding. The process of initial coding was performed by perusing each transcript, line-by-line, and categorizing large chunks of related content into nodes. In NVivo, a node is a container that holds raw data (i.e., text references).

Figure 3.3 illustrates the basic node structure resulting from the initial cycle coding. The numbers in parenthesis correspond to the total number of references deposited in each node.

This space intentionally left blank.

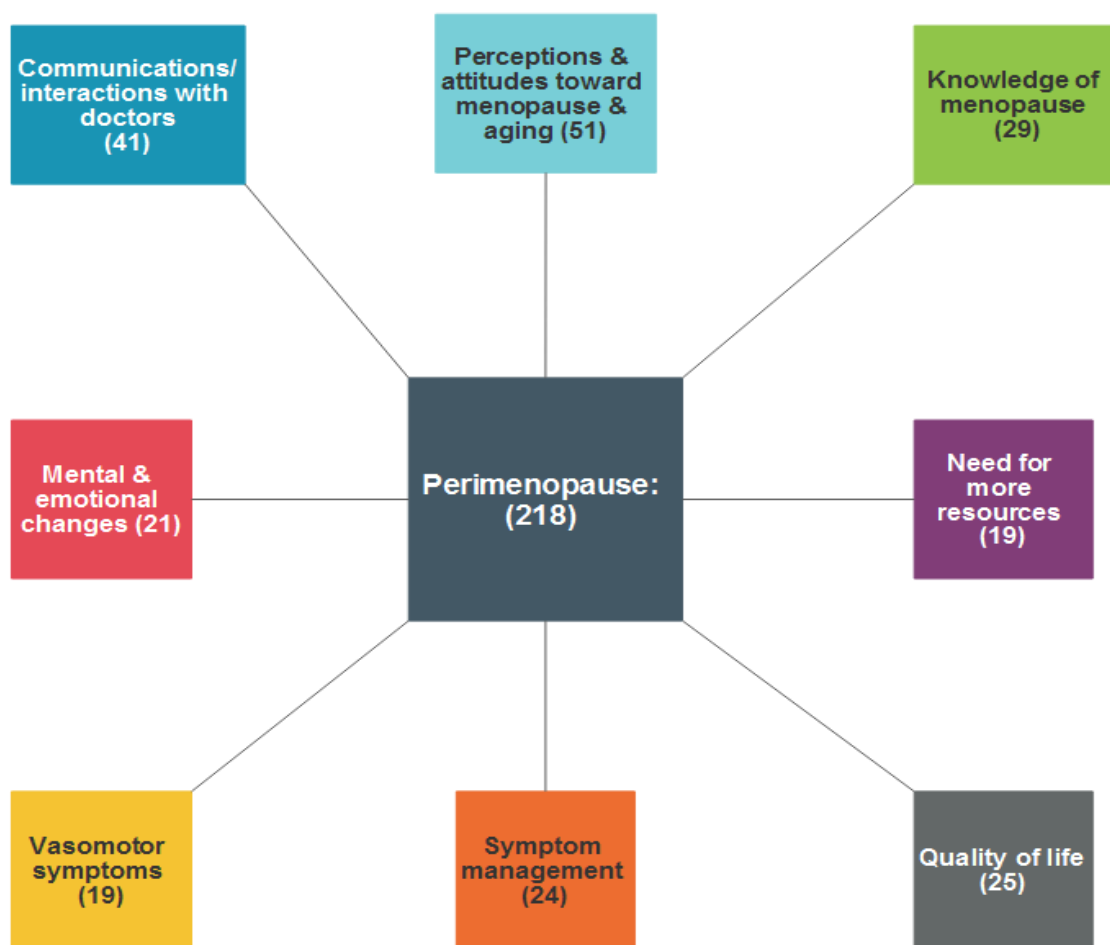


Figure 0.3 Basic node structure generated from initial cycle coding.

Second-cycle coding is a type of meta-analysis that involves reorganizing and reanalyzing data coded during the first cycle with the aim of generating more narrowly defined concepts and themes (Saldana, 2009). As a result of second-cycle coding, I identified 10 salient concepts, as illustrated in Figure 3.4:

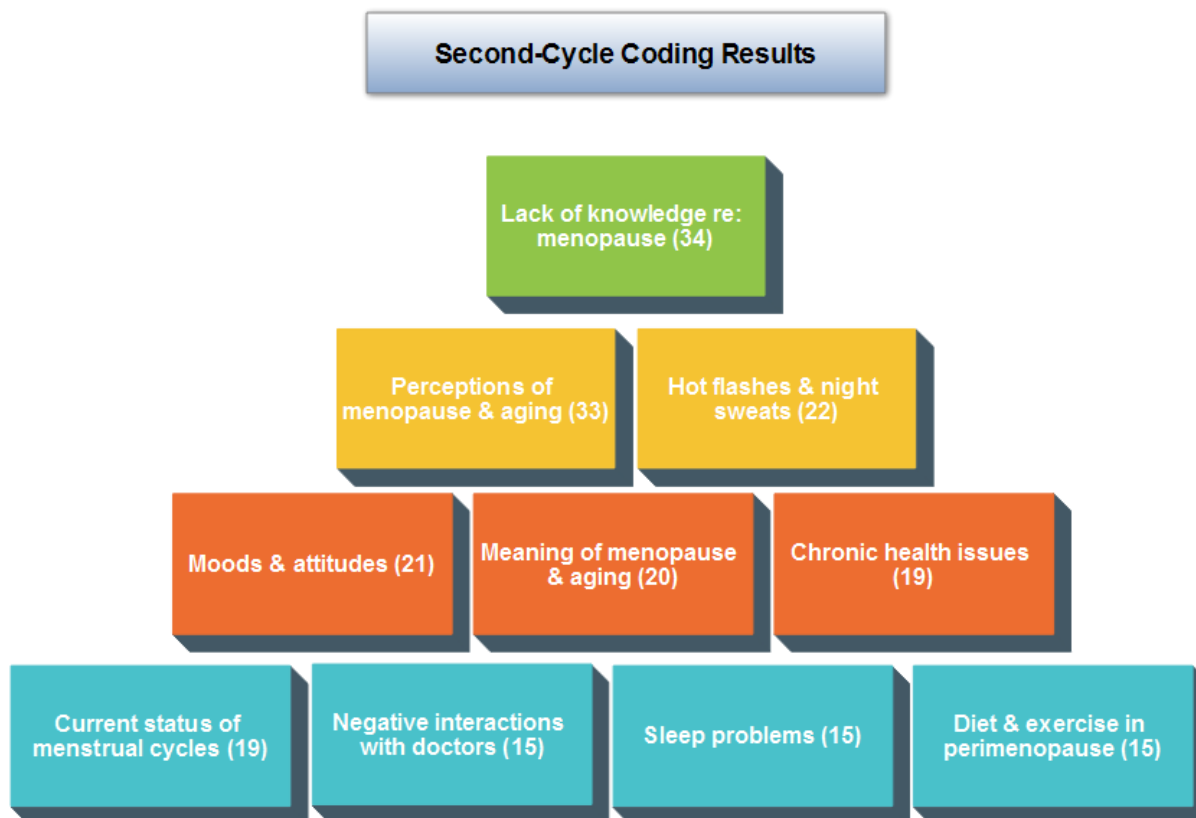


Figure 0.4 Second-cycle coding generated more narrowly defined concepts.

The final coding cycle, thematic coding, entailed an even closer examination of the second-cycle codes. In his discussion of “themeing” the data, Saldana (2009) observed, “A theme is an *outcome* of coding, categorization, and analytic reflection, not something that is, in itself, coded” (p. 139). Whittling down the number of themes developed in second-cycle coding produced five dominant and recurrent themes that represent the participants’ collective perimenopausal experiences and perceptions.

3.7 Evidence of Rigor

To enhance rigor, I employed three techniques researchers commonly use to establish credibility and trustworthiness of qualitative research (Lincoln & Guba, 1985): a) Thick description (Geertz, 1973); b) Member-checking, (Creswell, 2007); and c) Audit trail (Creswell, 2007). Thick description refers to the process of capturing the narratives of the participants’ lived

experiences with sufficient detail and depth as to make the participants' stories come alive. In using rich, thick description, the reader can readily grasp an understanding of, not only the participants' experiences, but the context in which the experiences were lived. In reporting the study's findings, numerous participant quotes were presented to provide thick, rich descriptions of the women's perimenopausal experiences.

Member checking is a technique whereby the researcher allows each participant an opportunity to inspect the data, analyses, interpretations, and/or research findings. To accomplish member checking for this study, I contacted participants by phone or text, (except one participant who could not be reached), and separately emailed each participant a summary of my findings. In addition, I asked each participant to review a listing of her direct quotes that I planned to use in reporting the study's results. Although only three participants responded to my request, feedback from these respondents was both validating and affirming. For instance, Carla exclaimed, "This is great! Thank you!" Grace confirmed, "Everything was on point!" Finally, Henrietta offered, "This study was very informative, fun, and I learned a lot! This lets me know I am not alone in this dynamic change of life. There's great hope." It should be noted that Annette and Henrietta volunteered to be participants in future research studies.

To further enhance rigor, NVivo™ tracked the computerized data analytic process (Bazeley, 2007), which is an integral part of the audit trail in this study. From the perusal of transcripts, to coding and theme development, to the reporting of findings and conclusions, audit trails increase research transparency. The entire audit trail in this study encompassed documentary evidence of data collection activities (e.g., completed screenings, demographic questionnaires, signed consent forms), the interview schedule, interview audio, handwritten interview notes, transcripts, memoranda of interviews, charts and diagrams, and analytic notes.

CHAPTER 4 FINDINGS

4.1 Introduction

This qualitative study was an IPA investigation of the lived experiences of eight low-income black women in perimenopause. Using intersectionality as a conceptual lens, the study was guided by two research questions:

- a) How do low-income black women in midlife perceive and manage the menopause transition?
- b) How do low-income black women in midlife understand and interpret their perimenopausal experiences in the larger context of aging?

Data analyses resulted in five qualitative themes that revealed how this sample of participants perceived and managed the menopause transition. As will be discussed in detail below, results further revealed how participants interpreted their change-of-life experiences in the context of aging. To give participants a voice in my research, I identified/labeled each theme with a direct quote representing the women's collective views and experiences:

- Theme 1: "I had no earthly idea it would take years—literally years!"
- Theme 2: "Give us some tangible things that we can grow from."
- Theme 3: "Honey, these hot flashes be off the chain!"
- Theme 4: "We just accept it; it's just a natural part of life."
- Theme 5: "I want to be rockin' and movin', but not in a chair!"

The main study findings were participants' lack of knowledge about menopause and the need for more information and resources (Themes 1 and 2), particularly from healthcare providers, to successfully navigate the menopause transition.

Concerning vasomotor symptoms (Theme 3), seven participants reported experiencing hot flashes, night sweats, and/or hot and cold spells, which were directly associated with sleeplessness. In their responses, participants conveyed the various ways in which they managed somatic changes. For participants in this study, menopause is just a natural part of life they have learned to accept (Theme 4). All eight participants related positive views toward aging and perceived midlife as a time of self-discovery, personal growth, and the pursuit of personal goals (Theme 5).

4.2 Results

In IPA, the researcher's interpretation of the participants' meaning-making is characterized as a double-hermeneutic (Bontekoe, 2000; Smith & Larkin, 2009). That is, in IPA, data analysis becomes a process wherein the researcher is making sense of the participant, who is making sense of their own lived experiences. Based on the data analysis procedures described herein, I identified five dominant and recurring themes during the second-cycle coding process, as illuminated in Figure 4.1:

This space intentionally left blank.

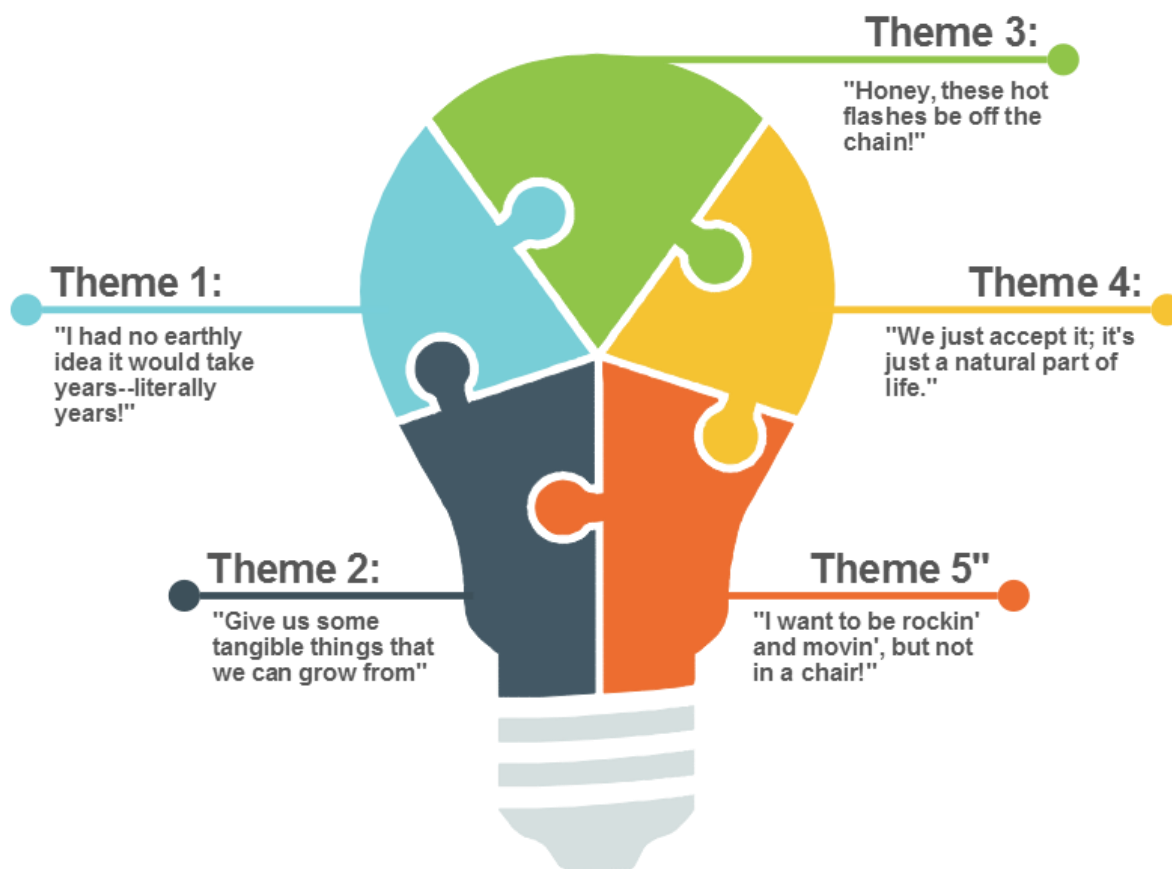


Figure 0.1 Themes identified in a study of low-income black women & the change of life
4.2.1 Theme 1: "I had no earthly idea it would take years—literally years!"

In this study, the most salient theme was participants' lack of knowledge and understanding about the menopause transition. This finding was closely correlated with a lack of knowledge about menstruation. Recalling the onset of their first menstrual cycle, all the participants indicated they were quite anxious and unprepared for menarche. Moreover, the women stated they received little to no information from caregivers or teachers about what to expect in menstruation. For instance, Annette, (age 57), was 13 when her first period began. She recounted, "I didn't know what was going on with my body." At age 13, 55-year-old Felicia, who was raised by her grandmother, indicated she did not know what was happening the first time she saw blood:

I just went to the bathroom . . . wiped and [said], ‘Oh, my God! Blood!’ So, I ain’t tell nobody for a minute ‘cuz I ain’t want nobody to think, ‘Oh, she done had sex’ or whatever. So, then it just—I was having a lot of cramps. Then I finally told my grandmama and she said, ‘Oh, child, go the hospital.’ I guess she wanted to make sure I hadn’t done had sex or something. And then once she did that, then they told her, ‘Oh, she done started her menstrual.’

Evidence of participants’ lack of knowledge regarding menstruation was further exemplified by Ellen’s (age 49) experience:

Well, I didn’t . . . know much about it because my, um, stepmom, she didn’t really talk about it to me. She didn’t really. . . tell me, physically, what a, um, young girl going into adulthood would experience. I never got that talk. So, I just took it, you know, as a grain of sand. This is how it’s supposed to go.

Participants’ lack of knowledge about menopause resounded throughout the data corpus. Although the women seemed to readily connect with the idea that perimenopause is related to aging (e.g., “We’re not at the age of bearing children anymore,” said Annette, “we become older.”), Carla, age 56, was the only participant who indicated she was aware of the 12-month barometer that determines when a woman finally reaches menopause. While Carla had been informed by her doctor of the 12-month timeframe, remarking, “That stuck in my head,” she was blown away by the fact that perimenopause takes place over a period of years. Thus, the title of Theme 1 aptly captures Carla’s shock at learning perimenopause takes place over a period of years. Carla exclaimed, “I had no earthly idea it would take years—literally years!” She promptly added, “I was under the impression that it was just like within a year or two . . . you’ll breeze through menopause and everything would be done.”

In interviews, I was struck by the women's candor in relating their lack of knowledge about this critical stage of life. For instance, Ellen responded, "I haven't learned anything about menopause. The only thing I heard was the hot flashes. That's all I heard; I don't know nothing else about it." Perhaps Ellen's difficulties with fibromyalgia and endometriosis throughout her life distracted her from focusing on perimenopause. In reviewing the interview transcript, I noted Ellen seemed to be more affected by her chronic health conditions than her perimenopausal symptoms.

As demonstrated by the women's candid responses, participants' lack of knowledge and understanding of perimenopause was influenced, at least in part, by myths and misinformation received from relatives and friends. For instance, Henrietta, age 50, recalled:

I heard my mom and my aunts, older aunts, talk about menopause, but they just say, "It start at 50 . . . so I'm under the impression at 50 I'll just stop my cycle—so confused, so confused.

Felicia's knowledge and understanding of menopause appeared to be based on what her grandmother told her: "My grandmama, before she died, she was still having the cycle. I think she died—she was 80-somethin'. And she was still having the cycle. At least that's what she told us." At age 55, Felicia's lack of knowledge was so limited she believed that some women skip menopause altogether, as reflected in the following statement:

Well, you know, I heard that everybody don't go through the, uh, menopausal stage, you know, some people reach 70 or whatever and never had menopause. So, I was hoping I would be one of those people, but I wasn't.

In sum, participants' lack of knowledge about menopause corresponded to their expressed need for information and resources to help them navigate the menopause transition.

4.2.2 Theme 2: *“Give us some tangible things that we can grow from.”*

The essence of Theme 2 is participants’ need and desire for more information and resources, particularly from healthcare providers. When asked if doctors offered information about menopause during medical appointments, four participants indicated doctors never raised the subject. Five participants acknowledged they may have received menopause pamphlets from their physicians or picked up pamphlets lying around in medical office waiting rooms. In interviews, none of the women conveyed a clear recollection of having read the pamphlets.

Within this sample, five participants indicated they had not sought menopause information from physicians, literature, or Internet sources. Among all participants, three accessed the Internet, at one time or another, seeking menopause information. Grace, age 49, visited WebMD and a menopause chat room. Notably, Grace appeared to be the most proactive in seeking information about menopause. Also, compared to other participants, Grace seemed to have a close relationship with her female gynecologist, with whom she often shared journal entries documenting her menstruation cycles and associated changes.

In my exploration of concepts related to a need for more information from doctors, I noted that at least four women were dissatisfied with doctors’ responses to their perimenopausal concerns. Among participants, Ellen, age 49, and Deborah, age 55, were the most vocal about doctor’s inattentiveness to their health concerns. In addition to perimenopause, Ellen has dealt with fibromyalgia, endometriosis, and fibroid tumors. Over the years, Ellen has had numerous interactions with doctors and other healthcare professionals regarding health issues that, collectively, have had a profound impact on her health and wellbeing. In addition to the above chronic health conditions, Ellen has experienced insomnia, chronic pain, and bouts of depression during perimenopause.

Due to the chronicity of her health conditions, it was difficult for Ellen to parse out which symptoms were associated with perimenopause versus the fibromyalgia, for instance. Ellen reflected, “When I was going through my illness of finding out that I had, um, fibromyalgia, um, that's when at night I would have—I would break out in real hot, you know, night sweats, not knowing it was related. It wasn't related to the fibromyalgia but just the changes I was going through . . . growing in age.”

In seeking medical assistance, Ellen recalled doctors' appointments at which she felt her perimenopause or other health concerns were not adequately addressed. At times, she even felt rushed at doctor's appointments. Ellen confided:

This is how my doctor's visit goes . . . ‘Okay, tell me what's wrong with you’ . . . And you tell them, ‘Oh, I've experienced this, this, and that. And, all of a sudden, you know, this comin' out of my arm, and pain going all down my arm, all in my foot, and my neck it sometimes gets stiff.’ And they're like, ‘Hmm. Well, Ellen, I guess we'll see you next time.’

Several years ago, Ellen was prescribed estrogen to treat symptoms associated with perimenopause. Until my interview with Ellen, she did not realize that estrogen was a form of hormone replacement therapy. Ellen disclosed that her doctor neglected to explain the pros and cons of HRT.

Deborah was equally dissatisfied with her doctor's response to gynecological concerns. She related feeling frustrated at her doctor's dismissive attitude when she requested a pap smear:

So, it's been some years, but every time I go to the doctor and tell him that--okay, last year I told him, ‘I need—I think I need a pap smear, you know, I haven't had one in a long time.’ ‘Oh, we going to get that the next time you come.’ It's always when I come,

‘We'll do that the next time,’ or, ‘I'm concerned about this, so we're gon' work on this first and then . . .’ So, you know—and that's what really be irking me ‘cuz I haven't had a pap smear in a long, long time.

Participant reports of negative communications and interactions with doctors also included feeling rushed at doctors' appointments, as Annette, age 57, recounted:

That's what I was gon' say. I—to be honest, I don't think she even had time. 'Cuz my appointment was about to get my, um, pap smear done, and she had other patients to go to. 'Cuz the clinic where I go, there's several people that get seen in the clinic, and, you know, maybe she would've had time, but I just didn't feel comfortable asking her.

In another example of negative interactions with doctors, Felicia was concerned about forgetfulness, a common complaint among perimenopausal women. On top of being anxious about her memory problems, Felicia had an encounter with a doctor that left her feeling misunderstood and frustrated:

I forget so much . . . but when I was going to Grayson [hospital pseudonym] and I was telling the doctor that I had—my primary doctor—then she was trying to get me some help. But . . . this man here that I see now, he's a white doctor. Sometimes I think he don't understand black folk because he's white. So I be telling him sometimes, I don't think you—ain't nobody in your family experienced it, or whatever. Or they probably experienced it whenever they was older. So you seem like you don't know, but I be coming and telling you. You ought to at least try to help me if I'm telling you what I'm going through. He don't seem like he all that concerned to me, though.

As indicated, Felicia believed race was a factor in communicating with her doctor. More specifically, she perceived racial difference and the doctor's lack of understanding as barriers to

addressing her perimenopausal concerns:

Yeah, I tell my doctor all the time, but then he be telling some', 'Oh, you don't need that. You ain't old enough to be going through—I say, 'Well, how old you got to be to go through?' And I was saying, 'Maybe I need to see a black doctor,' 'cuz the doctor I see now he's white and he thinkin' that, 'Oh, well, and you don't have that until you get this age. Most people don't get them kind of problems 'til they get a certain age.' But he always told me, 'You too young, you . . . probably just exaggerating.' No, I ain't exaggerating!

Frustrated at not being heard by her doctor, Felicia went on to say, "Yeah, when I tell him something he always laugh and think . . . everything I say is funny. So, I be looking like, okay, it's time for me to change doctors. But I don't want to keep changing, going through all these doctors, you know, but it seem like he never take me serious."

It is important to note that, in this sample, participants' distrust of doctors and avoidance of prescription medications emerged as barriers to seeking and receiving medical treatment. For instance, Grace, age 49, expressed strong negative reactions to taking prescription medicines:

I'm more of a natural person, because pharmaceutical to me is just like the average dope dealer. Only thing because they're legal. Let me explain a little bit better. Reason why I say pharmaceutical is like that since I'm on a recording is because if you go and you look at all of the side effects that certain medicine gives, that means I went to a doctor for this, 5 to 10 years later, I've gotta go back to the doctor for this.

In another instance of cultural distrust, Henrietta shared her experience of seeking medical treatment for heavy bleeding. She intimated a fear of doctors "experimenting" on patients:

Now that's what they—wasn't no clots, you know. And for a minute—they wanted, you know how they experiment on you if you let 'em, but I don't want to say. Yeah, um, I wasn't too keen on getting all these IUDs or anything that they felt could stop my heavy bleeding. I'm just not—if it's a natural way we can do something—one of the things, it was some type of a IUD, and they called it, uh, Mirena.

Although at least four participants reported negative interactions and/or communications with healthcare providers, three women recalled having an internist or gynecologist in the past with whom they felt comfortable and whom they felt adequately addressed their health concerns. Grace, who was the most proactive in seeking menopause information, reported having a very positive and open relationship with her gynecologist. For instance, when Grace experienced a bout of depression, Grace's gynecologist offered her cell phone number in the event Grace felt suicidal. By the same token, Betty commented on how understanding and helpful her internist was, describing the internist as a "very good doctor."

4.2.3 Theme 3: *"Honey, these hot flashes be off the chain!"*

Among all participants, the experience of vasomotor symptoms was a dominant and recurring theme. In fact, seven of eight participants reported experiencing hot flashes and/or night sweats on a regular basis. Commenting on her experience of hot flashes, Carla exclaimed, "Where do they come from? Oh, my God! I mean, it whips up inside of me and it just takes over!" Regarding night sweats, Carla further explained, "I have to get up, change clothes. It's a feeling like I'm trapped inside my body . . . and I can't get out." Deborah's description of her hot flash experiences was equally compelling:

The hot flashes, oh my God! I could just be sitting, and I just bust out in a sweat. I be so hot! Don't care if I take—if I stand in front of the fan, put my face in the refrigerator and

the freezer, I still be hot! I really don't like ice, but I will try to eat it. Or, it seem like if I drink the water . . . it seem like it cools it off a lil' bit. But then the flashes still—I mean I be literally be sweating!

Ellen, who suffers from fibromyalgia, described her first hot flash experience:

I never broke a sweat a day in my life until the summer of 2017. I just got hot [all] of a sudden. I mean I was sweating in my hair and everywhere. And I'm like, "Where is this coming from?"

Participants who experienced night sweats also complained of waking up in the middle of the night, as a result. For instance, Annette recounted:

I could be in a deep sleep and then all of a sudden, it'll come. And I get up and be running around trying to drink water, eating ice, and it still don't—so I just say, well, I guess it gotta take its course.

Due to recurrent night sweats, six participants reported early morning waking and trouble falling back to sleep. Reflecting on night sweats and sleeplessness, Felicia remarked, "I don't sleep—I don't sleep too good because of the flashes, I think." In a similar vein, Betty observed, "I used to sleep good until I started going through the changes."

In addition to vasomotor symptoms, a related complaint was the experience of alternating hot and cold spells. Four participants reported moments in which they felt hot and then cold in an alternating pattern. Annette, for instance, stated, "I'm having that a lot more often now, the night sweats. You'll be warm at first and then you might get cold all of a sudden—have to take the covers off." Regarding frequency, Carla stated she experiences hot flashes every day: "All the time—constantly. And then I get cold. I get cold." Similarly, Ellen described her experiences of hot flashes and alternating hot and cold spells:

In a way, you know, you never expected . . . you need all kinds of fans and stuff . . . it just pops up all of a sudden . . . without warning . . . make your body temperature real hot, and then all of a sudden it cools. Your body temperature cools down.

Carla's vasomotor symptoms interrupted her sleep patterns, as well. She described the off-and-on pattern of hot and cold spells this way: "I have to take the cover off me, and then I get cool again . . . it's just hot, cool, hot, cool."

In this study, participants reported a variety of strategies aimed at managing vasomotor symptoms. Taking cool showers or baths, drinking ice water, eating ice, using fans, lowering the thermostat, praying, and reading Scriptures were all reported as coping strategies among this sample of participants. Three participants' insomnia was so severe they sought medical attention.

Regarding symptom management in general, I queried participants about their knowledge of hormone replacement therapy (HRT). Consistent with their lack of knowledge of menopause, the women in this study also lacked knowledge of HRT. Three women indicated their physicians offered them estrogen to manage menopausal symptoms; however, none of the doctors volunteered an explanation of HRT, nor bothered to provide pros and cons of taking this form of therapy. The following transcript excerpt is representative of participants' lack of knowledge of HRT and their reluctance to try it:

Researcher: Has any doctor recommended hormone replacement therapy?

Participant: No.

Researcher: No? Have you ever wondered what that was or--

Participant: No, what is it?

Researcher: --that it might be helpful? They're pills, similar to birth control pills, but they are supposed to—

Participant: I had a doctor tell me—

Researcher: --put synthetic estrogen . . . in your body.

Participant: Yeah, I had a doctor ask me if I wanted some estrogen, and I told him, ‘No, I don’t think so.’ I hadn’t done any research on it, so I turned it down right then. But I have taken vitamins. I’ve taken a lot of herbal stuff, you know? Yep, and, like I said, ginger works wonders.

Overall, participants’ lack of knowledge and understanding of menopause, as well as HRT, indicates this sample of midlife women may be ill equipped to effectively manage the menopause transition. It is noteworthy that five participants in the study sample are 55 and over, which suggests this subgroup of women is likely in the latter stages of perimenopause. This finding points to the need for early intervention for low-income black women in terms of menopause awareness, education, and support.

4.2.4 Theme 4: “We just accept it; it’s just a natural part of life.”

In this study, participants addressed questions regarding their perceptions and attitudes toward the menopause transition. Amid complaints of hot flashes, night sweats, and the emotional ups and downs that accompany the change of life, participants voiced a collective resignation that perimenopause is “just a natural part of life” that they have learned to accept. Carla, 56, who spoke at length about a past drug addiction, expressed her acceptance of perimenopause, which also included the reality that menopause translates to no longer being able to bear children:

It's scary. It's depressing. Um, it took me, uh, for a whole year it was just as depressing as hell to me to think that, *Oh, God, my period's not gonna come on.* Because I always hoped that I would eventually have a baby. But now I know that I won't because I'm 56,

and if I did, I'd be mad as hell if I got pregnant. So, I would like to, um, now, I'm accepting it. Now, I'm at a stage of acceptance, but at first I was very afraid, very angry. Um, I would like to work with kids. I would love to be able to, um, maybe get in the foster system and maybe see if they could like give me babies or something to like maybe, you know, somebody told me that they'll get you housing and everything. So, I would love to work with babies.

Felicia, 55, who lacks health insurance, voiced a resolute acceptance of menopause by determining, "It ain't goin' nowhere." Her approach to perimenopause is to take it in stride along with other life experiences. Felicia expressed acceptance of menopause by speaking in a collective voice: "We already done figured out it's just something that will happen; so, we just accept it." As previously noted, seven participants manage at least one chronic health condition such as arthritis, hypertension, diabetes, or fibromyalgia, in addition to perimenopause.

Based on participants' responses, the consensus was that, in view of other things in daily life these women must contend with (e.g., financial challenges, chronic health conditions), perimenopause does not rank high on their list of priorities. Although seven participants voiced acceptance of perimenopause as a natural part of life, Henrietta, who saw a doctor about forgetfulness, expressed cognitive dissonance in her response: "You got to learn to accept [menopause], but when you in it, you don't want to hear that; but you want to make sure you're not going wacko."

Notably, participants' resolute acceptance of perimenopause and cultural distrust did not deter them from seeking help in managing symptoms. It is also noteworthy that participants' self-perceptions of being strong black women was not a deterrent in their help-seeking behaviors. Data analyses showed that all eight participants sought medical assistance for various symptoms

associated with perimenopause. For instance, Betty, Carla, Deborah, and Grace saw primary doctors for depressive symptoms. Ellen saw a doctor for chronic insomnia, which stemmed from both fibromyalgia and perimenopausal symptoms. Felicia, who feared she was experiencing early onset dementia, was assured by her doctor that forgetfulness is common among women in perimenopause. In sum, participants in this study readily accepted their change-of-life experiences, and, on some conscious level, recognized perimenopause as a part of the aging process. As discussed below, participants' attitudes toward aging in general were positive.

4.2.5 Theme 5: *"I want to be rockin' and movin' but not in a chair!"*

Concerning the menopause transition, a burning question for women in this study was, "When is it going to be over?" While participants readily accepted perimenopause as an integral part of aging, and have learned to cope with the various changes, they were anxious "to be done with" perimenopause. For instance, Carla, who has chronic pain symptoms, described the change of life as "the bane of my existence." She added, "Oh, my God . . . it's like so much of my life has been centered around my period. And then, lately, around my period stopping and, you know, it's just awful!"

Deborah, age 55, was convinced she has been in perimenopause since her mid-thirties. For two decades Deborah has complained to doctors about vasomotor symptoms, insomnia, mood swings, memory problems, and depressive symptoms. Among participants, Deborah was the most dissatisfied with doctors' responses to her health concerns. Frustrated by communication barriers with doctors, Deborah confided in her mother about symptoms such as hot flashes and night sweats. She reported, "So, I call my mama, my mama say, 'You going through your change.' I say, 'Well, how long does it take? 'Cuz I been going through changes for a long time now.'"

Ellen expressed confusion and uncertainty as to the different stages of menopause and how long the process lasts. During the interview, I took time to explain the distinctions between perimenopause, menopause, and postmenopause. More specifically, I explained that once a woman reaches menopause, she becomes postmenopausal. In her response, Ellen said, “Oh, no one ever explained [that] to me.” Despite Ellen’s chronic illnesses (e.g., fibromyalgia, endometriosis), which have compounded her perimenopausal symptoms, Ellen found the courage to look beyond her physical sufferings to perceive the change of life as a process of self-discovery. In a philosophical tone, Ellen stated, “Well, going through the change helped me find myself because, at first, I didn’t know myself.”

While, for the women in this study, the change of life represents a mixed bag of burdens and blessings, all participants conveyed a positive attitude toward aging in general. When asked to ascribe personal meaning to aging, participants viewed aging as a “blessing,” as well as an opportunity for personal growth. As an example, Annette reflected, “It’s just . . . growing. And as a woman getting older, getting to a new stage of life . . . we still have a lot that we can learn and need to learn. And I just feel like it’s a growing process.”

During the interview, Carla confided that for months she has avoided seeing a doctor about chronic abdominal pain and changes in her stool. In addition to these troubling symptoms, Carla has struggled with bouts of depression. Although Carla was prescribed antidepressants, she has avoided taking the medication. Carla, a Medicaid recipient, admitted being a procrastinator and a “great bearer of pain.” Assigning personal meaning to the prospect of aging, Carla reasoned:

As long as I have my mobility and I’m in my right mind, I can deal with aging. I can deal with peeing on myself. Once I get my body straight . . . I’m gonna keep it straight. But, um,

what I can't deal with is waking up and not knowing who I am or where I am. If it gets to that point, you know, then I'll feel like I gotta make a change . . . and go get some help—go get some assisted living or something.

When asked about the meaning of being a black woman in midlife, all the participants endorsed the SBW archetype. From the perspective of being a grandmother, Annette opined on the “legacy of strength and power” passed down through generations:

Going all the way back to, uh, when we were in Africa, our ancestors . . . I will say that being a black woman defines you as being strong, the first word—we are strong women. Um, as to our, just knowledge, um, embrace it with love, teaching, whether it be your children, your friends, your—I just find that we are always—the role that the black woman is in is always teaching and sharing good information and just . . . very powerful, strong women. I feel like a strong person. I'm always trying to teach and tell others about, um, things my son went through, and things as a younger woman, and I went through with him, and just . . . be encouraged and to be strong.

Henrietta, age 50, confided that she and her siblings were raised by a divorced mother who worked long hours to support the family. Additionally, Henrietta's mother financially supported her sister (Henrietta's aunt) who was legally blind and lived in the same household. Thus, Henrietta's view of black women was shaped primarily by her mother's and aunt's perspectives and likely the sociocultural climate of the 1950s and 60s. Against this backdrop, Henrietta grew up believing “black women can only go so far in life.”

In cultivating a strong relationship with God over the years, (perhaps as influenced by the maternal figures in her life), Henrietta developed her own opinion about the potential of black women and now believes black women are indeed strong. Commenting on her spiritual growth,

Henrietta offered, “I have a relationship with God . . . that has allowed me to be a better person. So, for me, reading the Bible, reading Christian literature . . . helps [my] overall wellbeing—spiritual, physical, and mental.”

As study results show, participants’ positive view of aging was influenced, at least in part, by maternal role models, the women’s personal identity as strong black women, and their ability to transcend adverse life experiences. Although participants in the study navigated the menopause transition with a lack of knowledge about this crucial life course, they readily accepted perimenopause and perceived it as an experience they can survive. Looking at the broader context of aging, participants espoused greater optimism.

For instance, imagining how she will age, Ellen exclaimed, “I want to be rockin’ and movin’, but not in a chair!” Expressing her personal views toward aging, Annette remarked, “I feel good about it, because . . . I’m looking forward to . . . my golden days, older days and stuff. Because with that comes wisdom.” Felicia, who was raised by her grandmother, exclaimed, “If I live to get old like my grandmama did, that’d be a blessing!” In sum, participants expressed no fear of aging; rather, they looked forward to the prospect of growing older. Even Carla, who has procrastinated about seeking medical care, said this about aging: “I think it’s a positive thing, you know? I just want my period to be over!”

4.2.6 RQs Answered

This study of low-income black women and the change of life was born out of an empirical curiosity about how this demographic perceives and manages the menopause transition (RQ1). Due to a paucity of studies investigating this understudied population, there is a lack of in-depth understanding about this group’s lived experiences in perimenopause. Using an IPA approach, this study sought to uncover how low-income black women understand and interpret

their perimenopausal experiences in the larger context of aging (RQ2). Thus, the study's overarching goal was aimed at enlarging researchers' understanding of the menopause transition based on a sample of eight participants who recounted their experiences with curiosity, candor, and humor.

In addressing RQ1, results of the study suggested this sample of low-income black women lacked knowledge and understanding of perimenopause, as documented by the participants' quotes in Theme 1. Participants' perceptions and understanding of perimenopause were limited to their somatic and emotional experiences (e.g., hot flashes, insomnia, mood swings). Symptom-reporting included irregular periods, vasomotor symptoms (i.e., hot flashes/night sweats), mood lability, irritability, sleeplessness, and forgetfulness. In terms of grasping the menopause transition from a biological perspective (e.g., hormonal fluctuations, gradual decreases in estrogen production, 12-month amenorrhea timeframe), knowledge deficiencies in this sample were apparent.

Emotional lability, such as mood swings and irritability, were also common complaints. To prevent reactions of "snapping," for instance, Betty, Deborah, and Felicia avoided socializing during periods when they were particularly vulnerable. In her self-consciousness about going through the change, for instance, Deborah has avoided social outings out of a concern that she may experience hot flashes or mood lability in public. She related, "I be thinkin' people might know that I'm going through my 'pause, and they'll be lookin' at me crazy." Other participants found it helpful to be transparent with significant others about their change-of-life experiences. As Grace and Henrietta endorsed, being open about how their perimenopausal symptoms impacted them elicited understanding and support from significant others.

Making dietary changes (e.g., consuming less fried foods, eating more produce), increasing activity levels (e.g., walking), and drinking more water were reported as helpful strategies in managing the menopause transition for participants. Carla stated that she likes fruits and vegetables, but because her food stamps typically run out before month's end, it's challenging to eat healthy all the time:

Increase my water, yeah. I try to do fruits and vegetables. But see, when it's the end of the food cycle, when food stamps, you know, I still get food stamps. So, when it's close to the end, there are no fruits and vegetables left at the house, you know. So, I try to buy a lot of fruits and vegetables with my stamps. And I do cabbage and oranges and stuff like that, and apples. I try to cook with a lot of fresh stuff.

Due to self-reported medical conditions such as diabetes and hypertension, modifications in diet and exercise were also adopted based on doctors' recommendations. Annette, Betty, Ellen, and Grace, for instance, indicated they were proactive in making dietary and activity changes in response to perimenopause.

Concerning memory changes, seven participants noticed being easily distracted and more forgetful than usual during the menopause transition. Unaware she was going through the change, Henrietta grew so anxious about her forgetfulness, she feared she was experiencing early onset dementia:

Now, something that was really frightening to me was forgetfulness. And I don't . . . hear too many women in menopause—if I just ain't been around a person that said it—kinda' like forgetting things. You know it'll be simple things, but . . . I freaked out, and my doctor was like, 'You're right where you're supposed to be,' and I was like, yeah, simple stuff like keys, or maybe come in the house, get ready to change your clothes and put

something to the side that you might be about to cook. You think you're putting it on the stove. You put it in the refrigerator. And then you done went around the house about five, six times. Then that worked up a sweat, and then I was doing this for a minute—like I felt like it wasn't every day, but if it was every two, three [days] . . . and I was trying to connect the dots, but . . . my doctor told me, 'Please, it's not dementia; you do not have it [chuckled].' I was like, 'I'm 50. Nobody in my family has it,' you know.

Generally, participants in the study were skittish about taking prescription drugs to address somatic symptoms. One exception was Henrietta, who reported that Celebrex has been extremely helpful in reducing the pain and discomfort of cramps before the onset of her period. The remaining seven women in the sample were more likely to report a preference for over-the-counter medicines (e.g., Ibuprofen, Tylenol) to manage pain and preferred herbal remedies (e.g., ginger tea) over prescription medications. Carla, who suffers from chronic abdominal pain, reported:

I boil ginger sometimes when my cycle would get ready to start. And I would make a tea out of ginger, honey, and a little lemon. Ginger has helped me a lot. Even though it makes me a little nauseous, I would still drink it, because I know it will calm down the cramps and everything.

This study further examined participants' meaning-making in relation to their change-of-life experiences. Specifically, RQ2 asks: How do midlife, low-income black women understand and interpret their perimenopausal experiences in the larger context of aging? As results indicated, participants in the study exhibited a rudimentary understanding that perimenopause is a function of reproductive aging. As elucidated in Theme 4, participants readily accepted that perimenopause is “a natural part of life;” and, although their understanding of the biological

process of aging was extremely limited, women in the study learned to adapt to the physiological and emotional vicissitudes associated with perimenopause.

On one hand, participants expressed being annoyed by symptoms such as hot flashes, night sweats, and insomnia; while, on the other hand, the women perceived perimenopause as a process of self-discovery and renewal. Ellen, who is biracial, and identified as “mixed,” maintained:

Well, going through the change helped me find myself, because at first, I didn't know myself. Trying to get to know yourself is not knowing what people say about you, but who you really identify within yourself. So, by my, um, parents not telling me the issues of my life when I was coming up or how to maintain myself going through . . . fibroids and endometriosis, knowing that I had it at a younger age. Coming up with that, I had to find who I was. And I couldn't depend on anyone else to tell me about myself. I had to find myself to tell myself about myself.

Grace echoed the concept of situating self-discovery in the context of aging by stating: “I don't look at it as, ‘Oh, Lord, I have to go through this’ . . . I look at how other women, you know, have grown through it, and how they talk about, you know, they got a chance to find they own selves in menopause.”

Examining the construct of age (i.e., midlife) as an intersecting social identity, Ellen quipped, “Age is just a number; it's not who you are.” Ellen's assertion that age is just a number supports her positive view toward aging, reflecting her desire to be active and productive in later life. Notably, none of the participants seemed to fear the prospect of getting older. In fact, when asked her thoughts about aging, Felicia stated in a matter-of-fact tone: “I do have thoughts about it [aging], but I have no fear of it.” Hence, participants in the study embraced the reality of aging

and associated growing older with personal growth, strength, and serving as a role model to family members and friends.

For women in this study, aging was viewed collectively as a “blessing,” a hallmark of maturity, strength, and wisdom. Although seven participants in the study managed chronic health conditions along with perimenopausal symptoms, and reported having financial challenges, participants viewed themselves as whole and valuable contributors within their respective spheres of influence. For instance, Annette ascribed meaning to her aging process as follows:

I’ve seen within my family and my friends that I have, on a personal level, grown—maturity-wise—and a lot wiser and able to share things that I read and enjoy with my family, opposed to my 20s and 30s, I wasn’t looking at life like this.

Along with voicing positive views toward aging, participants acknowledged that mid and later life can provide opportunities to reset goals and work towards accomplishing them. In this vein, participants felt they still had ample time to rediscover meaning and purpose in life and to actualize their dreams. Invoking her faith in God, Ellen resolved:

God told me He’s my strength in my weakness, so I have to keep pushing. So, if I keep pushing in the strength that God gives me, then I can find my purpose and my passion again to do what I need to do for my life. And not just for my life, the life of those that are connected to me.

Worried about her health, Carla expressed a renewed determination to seek medical attention:

[I]f I can ever get the primary care doctor to get . . . me a specialist, that’s what I’m gonna do. I think I’m just gonna go to Grayson [hospital pseudonym] in an ambulance and just refuse to leave until they. . . really just look at my needs. I’m just gonna—by any

means necessary—stay in y'all . . . emergency room until y'all take me somewhere and get me some names and get me hooked up with the people that I need to get my body right!

Amid recurrent and problematic symptoms that impact their quality of life, participants seemed to take their perimenopausal experiences in stride, and they refused to allow the negative aspects of such to dampen or distort their view toward aging in general. Perhaps due to their self-perceptions as strong black women, participants exhibited a survival mentality, which suggests that perimenopause is just one of life's challenges to overcome amid other challenges (e.g., chronic health conditions, economic hardships). Rather than perceive the change of life as something to *go* through, participants in this study opted to view perimenopause and aging as something to *grow* through.

4.3 Summary

The IPA strategy used in this study resulted in five dominant themes. Taken together, these themes give voice to the women's unique perspectives and honor the ways in which the women perceive and manage the menopause transition. Each theme, as developed from the iterative coding and interpretative process, shows how perimenopause is perceived by eight low-income black women who stand at the intersection of race, gender, SES, and midlife. Based on findings, the IPA methodology was a good fit for ferreting out how perimenopause has impacted the women's lives, how this stage of life has influenced their perceptions of menopause within the larger context of aging, and how participants have adapted to the menopause transition, specifically as it pertains to symptom management.

CHAPTER 5 DISCUSSION AND CONCLUSION

5.1 Discussion of Findings

Based on a thorough review of the extant literature, this study is one of the first known qualitative investigations of low-income black women in perimenopause. The majority of menopause research conducted over the past two decades has focused on the experiences and perspectives of white, middle-class women (e.g., Dillaway et al., 2008; Marnocha et al., 2011). In my review of the literature, I found only one study that was similar in its approach and methodology. Nixon et al. (2001) examined the menopausal experiences of 44 low-income black women recruited from a small rural town in a large eastern state. In contrast, my study sample was recruited from a large, urban city in the southeastern U.S. Geography is important to note, as the lived experiences of urban women may be quite different than those of rural women.

Based on their findings, Nixon and colleagues observed that participants' determination to remain strong was adaptive in coping with adverse life experiences. In the present study, the strong black woman (SBW) construct emerged, but was not one of the dominant themes. As demonstrated in Chapter 4, participants viewed themselves as strong black women; however, this perception did not deter the women from seeking help for various menopausal concerns.

Although participants reported seeking help in managing perimenopausal symptoms, I noted the women's help-seeking behaviors concerning their general health was hindered by cultural distrust. Characterizing herself as "a great bearer of pain," Carla has avoided seeing a doctor about chronic abdominal pain and changes in her stool. In addition, Carla was prescribed antidepressants for depression, but prefers to not take the medication. As noted in Chapter 4, Grace expressed strong negative views toward the pharmaceutical industry, comparing doctors'

prescription of medication to “drug dealing.” Finally, Deborah acknowledged being passive about her healthcare, stating she could not recall the last time she had a mammogram.

The most salient finding in the study was that participants lacked knowledge and understanding about the menopause transition. Results of this study validate prior research showing that low-income urban women lacked knowledge, not only of menopause, but also of hormone replacement therapy (Appling et al., 2000). Using a sample of predominantly urban, African American women ($N=215$), Appling and colleagues found that survey respondents were largely uninformed about menopause and HRT. Moreover, respondents knew little about the relationship between menopause and cardiovascular disease and the benefits of HRT in reducing the risk of heart disease.

In this study, participants’ lack of knowledge about menopause appeared to be correlated with participants’ lack of knowledge of menstruation, specifically at the onset of menses. Results of this study validate previous research findings that misinformation about women’s reproductive health is a common phenomenon among girls and women. Even in a sample of nine college-educated women, for instance, Buchanan, Villagran, and Ragan (2001) observed a pattern of misinformation and a lack of communication about menstruation and menopause, as well as a pattern of misinformation across the life span as participants shared their experiences in focus groups.

In their qualitative study of 17 low-income African American women (Mean age, 30) Cooper and Koch (2008) found there was a lack of constructive communication about menstruation throughout the participants’ lives. This finding comports with my research results, showing that participants had little to no prior knowledge of menstruation at the onset of menses. As discussed in Chapter 4, participants reported that maternal figures had not prepared them for

their first menstrual experience, which, in some cases, was frightening. Based on participants' accounts of their first menses, a shroud of secrecy surrounded menstruation. Due to a lack of communication about women's reproductive health, these findings suggest stigma may be associated with menstruation and menopause throughout the life course (Buchanan et al., 2001).

In terms of participant accounts, results of this study were compared with previous studies of white women in perimenopause. One of the main findings in this study was participants' reporting of frequent and severe hot flashes/night sweats. In their study of risk factors for African American and Caucasian menopausal women, Freeman et al. (2001) found that a higher percentage of African American women experienced hot flashes compared to white women⁸. In a population-based study, Miller and colleagues (2006) validated the same finding, documenting that African American participants were more likely than Caucasian women to report severe hot flashes and the occurrence of hot flashes for more than 5 years.

Consistent with findings documented in prior research (Dillaway, 2006; Marnocha et al., 2011), participants in the present study were confused and uncertain about when perimenopause starts and how long it lasts. This finding is related to Theme 1 as it pertains to participants' lack of menopause knowledge. Additionally, previous research shows black women are less likely to use HRT than white women (Shelton, Lees, & Groff, 2001). In fact, all the participants in the present study expressed reservations about using HRT. This finding is consistent with prior research on medication use in general, reflecting that black women are less likely to use prescription medications than white women (Solomon, Ruppert, Greendale, Lian, Selzer, & Finkelstein, 2016). Finally, previous research indicates black women are diagnosed with fibroid tumors at a much higher rate than white women (Jacoby et al., 2010). In the present study,

⁸ $N = 375$; 38% vs. 25%, respectively; $p = 0.01$

however, five participants had no history of fibroids, two participants were unsure, and only one woman (Ellen) was previously diagnosed with fibroid tumors.

5.2 Strengths & Limitations

As noted earlier, this research is one of few qualitative studies to target the lived experiences of low-income black women in perimenopause. Findings from this research target a sizable gap in the literature concerning this population's knowledge, understanding, and perceptions of menopause. Using an IPA approach, my research findings captured the essence of participants' experiences and perceptions as they traversed the menopause transition. As demonstrated by the themes identified, this study gives voice to participants' perceptions, attitudes, and beliefs about perimenopause using the participants' own words. Each of the five themes is illustrated and entitled by a direct participant quote.

The main strength of this study is that participants were given a rare opportunity to discuss, interpret, and make meaning of their change-of-life experiences in their own way, using their own words. Although a structured interview schedule was used to guide the discourse, the women were free to share as much or as little as they wished. This research is significant in that it expands researchers' understanding of an often elusive and mysterious transitional event in women's lives. Elucidating perimenopause in an understudied population contributes to the existing literature by shedding light how marginalized women perceive, understand, and interpret their perimenopausal experiences in the larger context of aging.

While this study makes an original contribution to the literature, there are a few limitations worth noting. First, a sample size of eight is relatively small; thus, study results may not be generalized to larger populations of perimenopausal women. Additionally, nonprobability

sampling methods (e.g., convenience sampling, snowball sampling) can result in sampling bias (Creswell, 2007).

Second, because participants volunteered for the study, self-selection bias may be a factor in the interpretation of results. More specifically, women who volunteered for the study may have different views and opinions about menopause and aging compared to women who did not volunteer. Third, the data obtained in this study were based on participant self-reporting. Gathering objective or corroborating information (e.g., from doctors) was beyond the scope of the study. Although these limitations are important to note, they do not outweigh the strengths and contributions of this original research.

5.3 Theoretical Implications

For decades, social scientists have drawn on an array of theoretical frameworks and conceptual models to guide research on human phenomena and behavior. A few examples include social learning theories (e.g., Bandura, 1986), life course theories (e.g., Dannefer, 2003), and attitude-behavior models (e.g., Andersen, 2008; Fishbein & Ajzen, 2010). Although conventional theoretical approaches have contributed much to our understanding of how people perceive, interpret, and make sense of their experiences, these approaches were developed based on studies conducted on predominately Caucasian populations, particularly white males (Gilligan, 1982/1993). From the 1970s, feminist scholarship began to shed light on the experiences of white, middle-class women (e.g., Belenky, Clinchy, Goldberger, & Tarule, 1986/1997); however, the experiences of women of color were summarily overlooked (Collins, 2000).

Because low-income black women are an understudied population, it was important to apply a conceptual framework that elucidates their unique experiences and perspectives,

especially those associated with health-related and quality-of-life concerns. Increasingly, health disparities researchers are employing intersectionality (Crenshaw, 1989, 1991) as a conceptual lens to explore the lived experiences of marginalized groups (Bauer, 2014; Dillaway, 2016; Nixon et al., 2001). Intersectionality theorists contend that the experiences and views of oppressed groups cannot be properly critiqued without analyzing the intersecting social identities (e.g., race, gender, class) that influence human behavior and experience.

Collins and Bilge (2016) argued that intersectionality is an analytic tool which helps researchers and others understand the lived experiences of disenfranchised groups. As a form of critical inquiry, intersectionality has the potential to link theory and practice in a way that empowers individuals and communities alike. Results from this study show that intersectionality was a useful tool in the examination of low-income black women and the change of life. The finding that study participants perceived themselves as strong and resilient in the face of adversity is consistent with previous findings in menopause research (Nixon et al., 2001).

Finally, study results showed that participants' help-seeking behaviors were strongly influenced by their perceptions, beliefs, and attitudes toward doctors, medical institutions, and pharmacology. As noted in Chapter 4, all eight participants reported seeing a doctor for symptoms related to perimenopause (e.g., insomnia, depression, heavy bleeding). At the same time, perhaps due to issues stemming from cultural distrust, participants were wary about using prescription medications and trying HRT to relieve menopausal symptoms. Although intersectionality was the organizing framework for this study, Andersen's (1995) healthcare utilization model would have worked well as a secondary framework. It may be insightful to examine the factors leading to participants' utilization of healthcare services (i.e., predisposing factors, enabling factors, and perceived need). For instance, enabling factors such as inadequate

income or the lack of health insurance, may impede the utilization of healthcare services among disadvantaged groups.

5.4 Methodological Implications

Planning research of African Americans' lived experiences should involve considerations that attend to cultural distrust, gaining access to participants, and collaborating with community stakeholders (Hughes et al., 2017). Due to past ethical misconduct by scientists conducting biomedical research (Hughes et al., 2017; Washington, 2006), African Americans as a group tend to be wary of scientific research. Given these methodological concerns, I approached the present study fully cognizant that ongoing challenges exist in recruiting African American subjects.

Of note, my status as an African American researcher in midlife offered an advantage in recruiting a hard-to-reach population over researchers who do not share the same racial/gender identity. Although shared race/ethnicity and menopause status with my participants facilitated rapport-building and trust; at the same time, I was consciously aware that SES differences (i.e., education and income) set us apart. Notwithstanding SES differences, I experienced relative ease in recruiting eight participants for the study, in part due to the effectiveness of snowball sampling techniques. During the four-month recruiting period (i.e., from January to May of 2018), a total of 23 women expressed interest in the study. Of this number, 15 women were excluded from participation due to menopause status or income. The amount of interest in the study shown over a relatively short period of time suggests that prospective participants were more than willing to share their perimenopausal experiences and views.

Qualitative research is appropriate for investigating lived experience and the myriad ways people interpret or make meaning of their experiences (Creswell, 2007). IPA (Smith et al., 2009)

was selected for this study because of its rich theoretical underpinnings (i.e., phenomenology and hermeneutics) and its straightforward data analysis approach. In addition, IPA is ideal for graduate student research, as recommended by Smith and colleagues. The use of small sample sizes allows for in-depth and incisive analyses, which enlarges the researcher's understanding of the phenomenon under study.

IPA worked well for this study because it facilitated the double-hermeneutic of allowing participants to describe and interpret their own experiences, while allowing the researcher to view, interpret, and make sense of participants' narratives and interpretations. Just as important, this IPA study gave voice to a group of marginalized women who are managing perimenopause along with other issues in their lives. In addition to managing perimenopause, for instance, seven participants also manage chronic health conditions. Findings from this study have major practice and policy implications, as discussed below.

5.5 Practice & Policy Implications

Given the main finding concerning a lack of knowledge and the need for more information about menopause, it is apparent that doctors and other healthcare providers have a duty to educate their patients about perimenopause and any hormone replacement therapies that might be effective in managing the menopause transition. In their interactions and communications with doctors, participants in this study complained that physicians failed to offer information about menopause, did not explain the pros and cons of HRT, and did not seem interested in helping them understand the changes taking place in their bodies. Not only that, at least four participants felt dismissed or rushed at doctor's appointments and felt their needs were not adequately addressed. For instance, Deborah stated that her primary doctor, a white male,

failed to take her seriously, did not understand her as a black woman, and dismissed her health concerns.

Not only should healthcare providers educate their patients, but they should take time to discuss menopausal concerns and furnish patients with pamphlets about menopause and HRT to take home. It was noted that at least four women in the study indicated they never saw pamphlets about menopause in primary physician waiting rooms. Besides healthcare providers, mental health professionals should be prepared to address menopausal concerns with their clients and make appropriate referrals to gynecologists or other specialty doctors. Also, community health agencies that provide services to older adults should offer information and provide educational materials and resources to midlife women. From a public health/behavioral intervention perspective, study results indicate an urgent need for menopause awareness campaigns in low-income black communities.

Lastly, seven participants in the study reported a chronic disease such as hypertension, high cholesterol, or diabetes. The Stanford University Chronic Disease Self-Management Program ([CDSMP]; Lorig, Sobel, Ritter, Laurent, & Hobbs, 2001), a 6-week educational workshop, was designed to help older adults manage their chronic health conditions. Based on findings from this study and previous research, it would be worth developing an intervention, similar to the CDSMP model, that provides education and support to peri/menopausal women, particularly to underserved populations.

5.6 Directions for Future Research

This study targeted a significant gap in the literature concerning the lived experiences of low-income black women in perimenopause. Thematic findings give voice to the experiences and perspectives of a group of women who had much to share about their journey through

perimenopause. Compared to middle-class Caucasian women, low-income black women are underrepresented in women's health research, regardless of the methodology. Based on a thorough review of studies published within the past 20 years, the menopausal experiences of low-income black women have largely gone understudied.

In terms of future menopause research, the field is wide open for studying racially diverse populations. Thus, researchers should target understudied populations in the conduct of quantitative, qualitative, and mixed methods studies. Though time-consuming, costly, and labor intensive, mixed methods studies offer the best of both worlds in terms of obtaining a comprehensive understanding of a given phenomenon. Notably, large, population-based studies, such as the Study of Women Across the Nation (SWAN), have recruited sizable samples of African American women in health research; however, studies of this nature and magnitude are few and far between. Notably, the SWAN study recruited women from the Midwest, the west coast, and other areas, but the southern region of the United States, which has the highest percentage of African Americans, was excluded. As noted in Chapter 2, the southern U.S. has the largest population of African Americans, many of whom live at or below the poverty level. Geographic and population differences are important to note, as they may be associated with health disparities.

In planning research of racially diverse populations, cultural considerations should include issues related to trust, power differentials between researcher and participant, gaining access to participants, and collaborating with community stakeholders (e.g., faith leaders). Moreover, researchers should be willing to share research findings with participants and disseminate findings to the larger community. In recruiting participants for this study, I established a working relationship with the branch manager of one of the interview sites. Once

my thesis is published, I plan to give presentations at local libraries to share findings with the community.

5.7 Overall Summary & Conclusion

Perimenopause is a major biological process in the life span of women, culminating in the cessation of menses. Colloquially referred to as “the change of life,” natural menopause is an integral part of the overall process of women’s aging. The present study was undertaken to examine the perimenopausal experiences of eight low-income, black women who volunteered to share their journey toward menopause and beyond. In addition, the study examined participants’ views toward menopause in the larger context of aging.

An IPA approach generated five recurrent themes that were systematically distilled from the women’s narratives. In sum, the study found that participants lacked knowledge of menopause (Theme 1), desired more information and resources from doctors (Theme 2), experienced primarily hot flashes, trouble sleeping, and mood lability (Theme 3), readily accepted the menopause transition as a natural part of life (Theme 4), and endorsed positive views toward aging (Theme 5). Findings from the study have practice and policy implications that invoke a clarion call for doctors and other healthcare professionals to educate their patients regarding menopause and HRT.

In contrast to middle/upper-class, Caucasian women, the experiences and perspectives of African American women in midlife have been grossly underrepresented in social science and public health research. Findings from this qualitative study address a significant gap in the literature concerning minority women’s perimenopausal experiences and their perceptions of aging. Although study findings reflect only the experiences and views of eight participants, this

research contributes to the empirical literature by giving voice to a marginalized group of women whose experiences would otherwise have gone unnoticed.

Given the dearth of research on low-income black women, researchers interested in minority women's health and reproductive aging should conduct more qualitative and mixed methods studies (e.g., surveys, focus groups, individual interviews) using larger samples. At the same time, researchers must be cognizant of various sociocultural barriers in the recruitment of racially diverse populations (e.g., fear and cultural distrust) and find innovative ways to overcome these barriers. In closing, researchers must be willing to collaborate with community stakeholders in their recruitment efforts and share findings with research participants and their communities.

REFERENCES

- Allen J. O. (2016). Ageism as a risk factor for chronic disease. *Gerontologist*, 56(4), 610-614.
doi:10.1093/geront/gnu158
- Andersen, R. (2008). National health surveys and the behavioral model of health services use. *Medical Care*, 46(7), 647-653.
- Appling, S. E., Allen, J. K., Van Zandt, S., Olsen, S., Brager, R., & Hallerdin, J. (2000). Knowledge of menopause and hormone replacement therapy use in low-income urban women. *Journal of Women's Health & Gender-Based Medicine*, 9(1), 57-66
- Avis, N. E., Assmann, S. F., Kravitz, H. M., Ganz, P. A., & Ory, M. (2004). Quality of life in diverse groups of midlife women: Assessing the influence of menopause, health status, and psychosocial and demographic factors. *Quality of Life Research*, 13, 933-946.
- Babbie, E. (2007). *The practice of social research* (11th ed.). Belmont, CA: Thomson Wadsworth.
- Ballard, K. D., Kuh, D. J., & Wadsworth, M. E. J. (2001). The role of the menopause in women's experiences of the change of life. *Sociology of Health & Illness*, 23(4), 397-424.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bauer, G. R. (2014). Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. *Social Science & Medicine*, 110, 10-17. Retrieved from <http://dx.doi.org/10.1016/j.socscimed.2014.03.022>
- Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1997). *Women's ways of knowing: The development of self, voice, and mind*. New York: Basic Books, Inc.
(Original work published 1986)

- Bontekoe, R. (2000). *Dimensions of the hermeneutic circle*. Amherst, NY: Humanity Books.
(Original work published 1996)
- Bazeley, P. (2007). *Qualitative data analysis with NVivo*. Los Angeles: Sage.
- Bowleg, L. (2012). The problem with the phrase women and minorities: Intersectionality-an important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267-1273. doi: 10.2105/AJPH.2012.300750
- Bowles, C. (1986). Measure of attitude toward menopause using the semantic differential model. *Nursing Research, 35*(2), 81-85.
- Buchanan, M. C., Villagran, M. M., & Ragan, S. L. (2001). Women, menopause, and (Ms.)information: Communication about the climacteric. *Health Communication, 14*(1), 99-119.
- Close, H., Mason, J. M., Wilson, D., & Hungin, A. P. S. (2012). Hormone replacement therapy is associated with gastro-oesophageal reflux disease: A retrospective cohort study. *BMC Gastroenterology, 12*, 56-65. Retrieved from <http://www.biomedcentral.com/1471-230X/12/56>
- Coker, A. D., Huang, H., & Kashubeck-West, S. (2009). Research with African Americans: Lessons learned about recruiting African American women. *Journal of Multicultural Counseling and Development, 37*, 153-165. Retrieved from [http://onlinelibrary.wiley.com/journal/10.1002/\(ISSN\)2161-1912](http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)2161-1912)
- Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (2nd ed.). New York, NY: Routledge.
- Collins, P. H., & Bilge, S. (2016). *Intersectionality: Key concepts*. Malden, MA: Polity Press.

- Cooper, S. C., & Koch, P. B. (2008). "Nobody told me nothin": Communication about menstruation among low-income African American women. *Women & Health*, 46(1), 57-78. Retrieved from https://doi.org/10.1300/J013v46n01_05
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *The University of Chicago Legal Forum*, 140, 139-167.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43, 1241-1299.
- Crenshaw, K., Gotanda, N., Peller, G., & Kendall, T. (Eds.). (1995). *Critical race theory: The key writings that formed the movement*. New York: The New Press.
- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Dannefer, D. (2003). Cumulative advantage/disadvantage and the life course: Cross-fertilizing age and social science theory. *Journal of Gerontology: SOCIAL SCIENCES*, 58B(6), S327-S337.
- Dasgupta, D., & Ray, S. (2017). Is menopause status related to women's attitudes toward menopause and aging? *Women & Health*, 57(3), 311-328. Retrieved from <http://dx.doi.org/10.1080/03630242.2016.1160965>
- Dillaway, H. E. (2006). When does menopause occur, and how long does it last? Wrestling with age- and time-based conceptualizations of reproductive aging. *NWSA Journal*, 18(1), 31-61.

- Dillaway, H., Byrnes, M., Miller, S., & Rehan, S. (2008). Talking "among us": How women from different racial-ethnic groups define and discuss menopause. *Healthcare for Women International*, 29, 766-781. doi: 10.1080/07399330802179247
- Dillaway, H. E. (2016). Are hysterectomies necessary? Racial-ethnic differences in women's attitudes. *Journal of Women & Aging*, 28(4), 309-321. Retrieved from <http://dxdoi.org/10.1080/08952841.2015.1017429>
- Fishbein, M., & Ajzen, I. (2010). *Predicting and changing behavior: The reasoned action approach*. New York: Psychology Press, Taylor & Francis Group.
- Freeman, E. W., Sammel, M. D., Grisso, J. A., Battistini, M., Garcia-Espagna, B., & Hollander, L. (2001). Hot flashes in the late reproductive years: Risk factors for African American and Caucasian women. *Journal of Women's Health & Gender-Based Medicine*, 10(1), 67-77.
- Gadamer, H. (2004). *Truth and method* (2nd ed., Rev.). New York: Continuum International Publishing Group. (Original work published 1975)
- Gary, F., Still, C., Mickels, P., Hassan, M., & Evans, E. (2015). Muddling through the health system: Experiences of three groups of black women in three regions. *The Journal of the National Black Nurses Association*, 26(1), 22-29.
- Geertz, C. (1973). *The interpretation of cultures: Selected essays*. New York: Basic Books, Inc.
- George, S. A. (2002). The menopause experience: A woman's perspective. *JOGNN Clinical Studies*, 31, 77-85.
- Georgia State University, Research Services and Administration. (2017). Compliance and safety. In *Human subjects (IRB)*. from <http://ursa.research.gsu.edu/human-subjects/>

- Gilligan, C. (1993). *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press. (Original work published 1982)
- Gines, K. T. (2011). Black feminism and intersectional analyses: A defense of intersectionality. *Philosophy Today*, 55, 275-284.
- Gold, E. B., Colvin, A., Avis, N., Bromberger, J., Greendale, G. A., Powell, L., Sternfeld, B., & Matthews, K. (2006). Longitudinal analysis of the association between vasomotor symptoms and race/ethnicity across the menopausal transition: Study of women's health across the nation. *American Journal of Public Health*, 96(7), 226-235.
- Grodstein, F., Manson, J. E., & Stampfer, M. J. (2006). Hormone therapy and coronary heart disease: The role of time since menopause and age at hormone initiation. *Journal of Women's Health*, 15(1), 35-45.
- Harnois, C.E. (2014). Are perceptions of discrimination unidimensional, oppositional, or intersectional? Examining the relationship among perceived racial-ethnic-, gender-, and age-based discrimination. *Sociological Perspectives*, 57(4), 470-487.
- Harlow, S. D., Gass, M., Hall, J. E., Lobo, R., Maki, P., Rebar, R. W., Sherman, S., Sluss, P. M., & de Villiers, T. J. (2012). Executive summary of the stages of reproductive aging workshop + 10: Addressing the unfinished agenda of staging reproductive aging. *Climacteric*, 15, 105-114. doi: 10.3109/13697137.2011.650656
- Hess, R., Thurston, R. C., Hays, R. D., Chang, C-C. H., Dillon, S. N., Ness, R. B., Bryce, C. L., Kapoor, W. N., & Matthews, K. A. (2012). The impact of menopause on health-related quality of life: Results from the STRIDE longitudinal study. *Quality of Life Research*, 21, 535-544. doi: 10.1007/s11136-011-9959-7
- hooks, b. (1981). *Ain't I a woman: Black women and feminism*. Boston, MA: South End Press.

- Huffman, S. B., Myers, J. E., Tingle, L. R., & Bond, L. A. (2005). Menopause symptoms and attitudes of African American women: Closing the knowledge gap and expanding opportunities for counseling. *Journal of Counseling & Development, 83*, 48-57.
- Hughes, T. B., Varma, V. R., Pettigrew, C., & Albert, M. S. (2017). African Americans and clinical research: Evidence concerning barriers and facilitators to participation and recruitment recommendations. *The Gerontologist, 57*(2), 348-358. doi: 10.1093/geront/gnv118
- Im, E.-O., Lee, S. H., & Chee, W. (2010). Black women in menopausal transition. *JOGNN, 39*, 435-443. doi: 10.1111/j.1552-6909.2010.01148.x
- Jacoby, V. L., Fujimoto, V. Y., Giudice, L. C., Kuppermann, M., & Washington, A. E. (2010). Racial and ethnic disparities in benign gynecologic conditions and associated surgeries. *American Journal of Obstetrics and Gynecology, 202*(6), 514-521. Retrieved from <https://doi.org/10.1016/j.ajog.2010.02.039>
- Katz, R. V., Green, L., Kressin, N. R., James, S. A., Wang, M. Q., Claudio, C., & Russell, S. L. (2009). Exploring the legacy of the Tuskegee syphilis study: A follow-up study from the Tuskegee legacy project. *Journal of the National Medical Association, 101*(2), 179-183. Retrieved from <http://nmanet.org/>
- Kline, C. E., Irish, L. A., Buysse, D. J., Kravitz, H. M., Okun, M. L., Owens, J. F., & Hall, M. H. (2014). Sleep hygiene behaviors among midlife women with insomnia or sleep-disordered breathing: The SWAN sleep study. *Journal of Women's Health, 23*(11), 894-904. doi: 10.1089/jwh.2014.4730

- Li, S., Roseberg, L., Wise, L. A., Boggs, D. A., LaValley, M., & Palmer, J. R. (2013). Age at natural menopause in relation to all-cause and cause-specific mortality in a follow-up study of U.S. Black women. *Maturitas*, 75, 246-252. Retrieved from <http://dx.doi.org/10.1016/j.maturitas.2013.04.003>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.
- Lorig, K. R., Sobel, D. S., Ritter, P. L., Laurent, D., & Hobbs, M. (2001). Effects of a self-management program on patients with chronic disease. *Eff Clin Pract.*, 4, 256-262.
- Mansfield, P. K., & Bracken, S. (2003). The Tremin Program: Sixty-eight years of research on menstruation and women's health. *Women's Studies Quarterly*, 31(1/2), 25-41. Retrieved from www.jstor.org
- Mansfield, P. K., Carey, M., Anderson, A., Barsom, S. H., & Koch, P. B. (2004). Staging the menopausal transition: Data from the Tremin research program on women's health. *Women's Health Issues*, 14, 220-226. doi: 10.1016/j.whi.2004.08.002
- Marnocha, S. K., Bergstrom, M., & Dempsey, L. F. (2011). The lived experience of perimenopause and menopause. *Contemporary Nurse*, 37(2), 229-240.
- Masson, H., Balfe, M., Hackett, S., & Phillips, J. (2013). Lost without a trace? Social networking and social research with a hard-to-reach population. *British Journal of Social Work*, 43, 24-40. doi: 10.1093/bjsw/bcr168
- Meyer, V. F. (2003). Medicalized menopause, U.S. style. *Healthcare for Women International*, 24, 822-830. doi: 10.1080/0739930390229939
- Miller, S. R., Gallicchio, L. M., Lewis, L. M., Babus, J. K., Langenberg, P., Zacur, H. A., & Flaws, J. A. (2006). Association between race and hot flashes in midlife women. *Maturitas*, 54, 260-269. doi: 10.1016/j.maturitas.2005.12.001

- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- National Center for Health Statistics. (2016). *Health, United States, 2015: With special feature on racial and ethnic health disparities*. Hyattsville, MD.
- Newhart, M. R. (2013). Menopause matters: The implications of menopause research for studies of midlife health. *Health Sociology Review*, 22(4), 365-376.
- Nixon, E., Mansfield, P. K., Kittell, L. A., & Faulkner, S. L. (2001). "Staying strong": How low-income rural African American women manage their menopausal changes. *Women & Health*, 34(2), 81-95. Retrieved from http://dx.doi.org/10.1300/J013v34n02_06
- Nixon, G., Evans, K., Kalischuk, R. G., Solowoniuk, J., McCallum, K., & Hagen, B. (2013). Female gambling, trauma, and the not good enough self: An interpretive phenomenological analysis. *International Journal Mental Health Addiction*, 11, 214-231. doi: 10.1007/s11469-012-9413-2
- Nosek, M., Kennedy, H. P., Beyene, Y., Taylor, D., Gilliss, C., Lee, K. (2010). The effects of perceived stress and attitudes toward menopause and aging on symptoms of menopause. *Journal of Midwifery Women's Health*, 55, 328-334. doi: 10.1016/j.jmwh.2009.09.005
- Palmer, J. R., Rosenberg, L., Wise, L. A., Horton, N. J., & Adams-Campbell, L. L. (2003). Onset of natural menopause in African American women. *American Journal of Public Health*, 93(2), 299-307.
- Paramsothy, P., Harlow, S. D., Greendale, G. A., Gold, E. B., Crawford, S. L., Elliott, M. R., Lisabeth, L. D., & Randolph, J. F. (2014). Bleeding patterns during the menopausal transition in the multi-ethnic study of women's health across the nation (SWAN): A

- prospective cohort study. *BJOG: An International Journal of Obstetrics & Gynecology*, 121, 1564-1573. doi: 10.1111/1471-0528.12768
- Pearce, G., Thogersen-Ntoumani, C., Duda, J. L., & McKenna, J. (2014). Changing bodies: Experiences of women who have undergone a surgically induced menopause. *Qualitative Health Research*, 24(6), 738-748. doi: 10.1177/1049732314529664
- Peddada, S. D., Laughlin, S. K., Miner, K., Guyon, J. P., Haneke, K., Vahdat, H. L., . . . Baird, D. D. (2008). Growth of uterine leiomyomata among premenopausal black and white women. *PNAS*, 105(50), 19887-19892. Retrieved from <http://www.pnas.org/cgi/doi/10.1073/pnas.0808188105>
- Reed, S. D., Lampe, J. W., Qu, C., Gundersen, G., Fuller, S., Copeland, W. K., Newton, K. M. (2013). Self-reported menopausal symptoms in a racially diverse population and soy food consumption. *Maturitas*, 75, 152-158. Retrieved from <http://dx.doi.org/10.1016/j.maturitas.2013.03.003>
- Rogers, J., & Kelly, U. A. (2011). Feminist intersectionality: Bringing social justice to health disparities research. *Nursing Ethics*, 18(3), 397-407. doi: 10.1177/0969733011398094
- Rosenberg, L., Adams-Campbell, L., & Palmer, J. R. (1995). The black women's health study: A follow-up study for causes and preventions of illness. *J Am Med Women's Assoc*, 50, 56-58.
- Rossouw, J. E., Manson, J. E., Kaunitz, A. M., & Anderson, G. L. (2013). Lessons learned from the women's health initiative trials of menopausal hormone therapy. *Obstet Gynecol.*, 12(1), 172-176. Retrieved from <http://www.ncbi.nlm.nih.gov>
- Samuels, G. M., & Ross-Sheriff, F. (2008). Identity, oppression, and power. *Affilia: Journal of Women and Social Work*, 23(1), 5-9. Retrieved from <http://online.sagepub.com>

- Shelton, A. J., Lees, E., & Groff, J. Y. (2001). Perceptions of hormone replacement therapy among African American women. *Journal of Health Care for the Poor and Underserved*, 13(3), 347-359.
- Sikkens, E., van San, M., Sieckelinck, S., Boeijs, & de Winter, M. (2017). Participant recruitment through social media: Lesson learned from a qualitative radicalization study using Facebook. *Field Methods*, 29(2), 130-139. doi: 10.1177/1525822X16663146
- Skloot, R. (2010, 2011). *The immortal life of Henrietta Lacks*. New York: Broadway Books.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis*. Los Angeles: Sage.
- Smith, J. A. & Osborn, M. (2008). Interpretive phenomenological analysis. In Smith, J. A. (Ed.), *Qualitative psychology: A practical guide to methods* (2nd ed., Vols. 53-80). London: Sage.
- Sutton-Tyrell, K., Selzer, F., Sowers, M., Neer, R., Powell, L., Gold, E., Greendale, G., Weiss, G., Matthews, K., & McKinlay, A. Study of Women's Health Across the Nation (SWAN) [Baseline dataset]. (1996-1997). ICPSR28762-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2014-02-04. Retrieved from <http://doi.org/10.3886/ICPSR28762.v2>
- The Boston Women's Health Book Collective. (2006). *Our bodies, ourselves: Menopause*. New York: Touchstone.
- The North American Menopause Society. (2015). *The menopause guidebook* (8th ed.). Mayfield Hts., OH: The North American Menopause Society.

- The North American Menopause Society (NAMS). (2017). *Menopause* (chap. 1). from <https://www.menopause.org/publications/clinical-care-recommendations/chapter-1-menopause>
- Trabert, B., Wentzensen, N., Yang, H. P., Sherman, M. E., Hollenbeck, A., Danforth, K. N., Park, Y., Brinton, L. A. (2012). Ovarian cancer and menopausal hormone therapy in the NIH-AARP diet and health study. *British Journal of Cancer*, 107, 1181-1187. doi: 10.1038/bjc.2012.397
- Ulin, P. R., Robinson, E. T., & Tolley, E. E. (2005). *Qualitative methods in public health: A field guide for applied research*. San Francisco, CA: Jossey-Bass.
- U. S. Census Bureau. (1999). *State and county quick facts*. Retrieved from <http://www.quickfacts.census.gov>
- U.S. Census Bureau. (2006). *Selected characteristics of baby boomers 42-60 years old in 2006 powerpoint (a powerpower slide presentation of select geographic, age, SES, race, and gender characteristics of the baby boomer generation)*. Washington, DC: U.S. Census Bureau, Age and Special Populations Branch.
- U. S. Census Bureau. (2010). *Poverty thresholds by size of family and number of children*. Retrieved from <http://www.census.gov/hhes/www/poverty/data/threshld/index.html>
- U.S. Census Bureau. (2011). *The black population: 2010* Retrieved from <https://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf>
- U.S. National Library of Medicine, Medical Encyclopedia. (2015). *Menopause*. Retrieved May 13, 2017 from <https://medlineplus.gov>
- U.S. Department of Health and Human Services, Office on Women's Health. (2010). *Menopause*. Retrieved May 20, 2017 from <https://www.womenshealth.gov/menopause>

- U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (2017). *Poverty guidelines*. from <https://aspe.hhs.gov/poverty-guidelines>
- van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). London, Ontario, CN: The Althouse Press. (Original work published 1990)
- Wachtel, M. S., Yang, S., Dissanaik, S., & Margenthaler, J. A. (2015). Hormone replacement therapy, likely neither angel nor demon. *PLoS ONE*, *10*(9), 1-11. doi: 10.1371/journal.pone.0138556
- Washington, H. A. (2006). *Medical apartheid*. New York: Anchor Books.
- Weiss, G., Noorhasan, D., Schott, L. L., Powell, L., Randolph, J. F., & Johnston, J. M. (2009). Racial differences in women who have a hysterectomy for benign conditions. *Women's Health Issues*, *19*(3), 202-210.
- West, C., Stewart, L., Foster, K., & Usher, K. (2012). The meaning of resilience to persons living with chronic pain: An interpretive qualitative inquiry. *Journal of Clinical Nursing*, *21*, 1284-1292. doi: 10.1111/j.1365-2702.2011.04005.x
- Whiteley, J., DiBonaventura, M., Wagner, J-S., Alvir, J., & Shah, S. (2013). The impact of menopausal symptoms on quality of life, productivity, and economic outcomes. *Journal of Women's Health*, *22*(11), 983-991. doi: 10.1089/jwh.2012.3719
- Yanikkerem, E., Koltan, S. O., Tamay, A. G., & Dikayak, S. (2012). Relationship between women's attitude towards menopause and quality of life. *Climacteric*, *15*, 552-562. doi: 10.3109/13697137.2011.637651

APPENDICES

Appendix A: Recruiting Flyer

Going through “the change of life?”

Then let’s talk about it! If you are a low-income, black woman between the ages of 45 and 58 and have not had a hysterectomy, you are invited to take part in a GSU study about the menopause transition. Up to 15 women are needed for this study. A 90-minute, face-to-face interview is required. For more information about this voluntary study, please contact Pamela at:

470-583-9017



Appendix B: Screening Tool

1. Full name:
2. How did you hear about the study?
3. Age/DOB:
4. Race/ethnicity:
5. To your knowledge, are you pregnant?
6. Have you had a hysterectomy?
7. What is the month/year of your last menstrual period?
8. What is your total household income?
9. How many people live with you?
10. Do you receive any form of public assistance (e.g., SNAP, Medicaid, etc.)?
11. Can you tell me about the signs and symptoms you are experiencing that lead you to believe you are currently going through “the change?”
12. Do you have any chronic health conditions or mobility issues that could limit your participation in this study?
13. The face-to-face interviews will be audio recorded and should take about 90 minutes. Do you consent to being audio recorded?
13. When is the best day/time for an interview; and how soon are you available?
14. What part of town do you live in?
15. Are you able to travel to the interview site?
16. Are you willing to answer any follow-up questions by phone after the face-to-face interview?
17. At this point, do you have any questions about the study?

Appendix C: Demographic Check Sheet

Annual household income:

- ☐ \$0 - 9,999
- ☐ \$10,000 - 19,999
- ☐ \$20,000 - 29,999
- ☐ \$30,000 - 39,999

Number of people living in household:

- ☐ 1 - 2
- ☐ 3 - 4
- ☐ 5 - 6
- ☐ 6 - 7
- ☐ 8 - 9
- ☐ 10 +

Public assistance:

- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Food Stamps (SNAP)
- ☐ Women, Infants, & Children (WIC)
- ☐ Medicaid/Medicare
- ☐ Home Energy Assistance Program

Dependents:

- ☐ 1 - 2
- ☐ 3 - 4
- ☐ 5 - 6
- ☐ 7 +

Education level:

- ☐ 9th grade
- ☐ 10th grade - 12th grade
- ☐ 1 - 2 years of college
- ☐ 3 - 4 years of college
- ☐ 5 - 6 years of college

Occupation & number of hours worked each week:

- ☐ 1 - 20
- ☐ 21 - 39
- ☐ 40 +

Religious/spiritual affiliation: _____

Sexual orientation:

- ☐ Heterosexual
- ☐ Bisexual
- ☐ Lesbian
- ☐ Other: (specify)

Marital status:

- ☐ Single
- ☐ Married
- ☐ Legally separated
- ☐ Divorced
- ☐ Currently living with a partner

How would you rate your health in general:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Age of first menstrual cycle: _____

Appendix D: Informed Consent

Georgia State University Department of Gerontology

Title: A study of low-income black women and “the change of life”

Principal Investigator (PI): Dr. Candace Kemp

Student Principal Investigator (PI): Pamela Manley

I. Purpose:

You are invited to take part in a research study. The purpose of this study is to explore the experiences of low-income black women who are going through “the change of life.” Going through “the change of life” means you may skip periods. You may also have hot flashes, night sweats, trouble sleeping, mood swings, or other changes.

You are invited to take part in the study because you are a black woman between 45 and 58 years of age, low-income, and going through “the change.” A total of 15 women will be chosen for this study. Taking part in this study will take about 2 hours of your time, including a 90-minute, face-to-face interview and a 30-minute follow-up interview on the phone. Interview dates and times will be scheduled at your convenience.

II. Procedures:

If you take part in this study, you will be asked to fill out a form that asks for personal information such as income, marital status, grade level, and health. Pamela Manley, the student PI, will interview you about your experiences. The face-to-face interview will last about 90 minutes and will be held at a site close to your home or work.

The interview will be audio recorded. I will ask questions about your personal experiences, views on “the change,” and how this stage of life affects you. You are free to answer questions in your own words, in your own way. There are no right or wrong answers. This study is about YOU and your experiences. A week to 10 days after the interview, I will call you to schedule a 15- to 30-minute phone interview for follow-up. We will review your transcript on the phone. I will make corrections, if needed.

III. Risks:

In this study, the interview is like having a one-on-one talk with the researcher about your “change-of-life” experiences. You will not have any more risks than you would have in a normal day of life.

IV. Benefits:

Taking part in the study may benefit you personally. Although there are no guarantees, you may experience increased personal growth by taking part. Overall, we hope to gain information about how low-income black women feel about “the change of life.”

V. Payment:

For taking part in the study, you will be paid \$25 in cash after the face-to-face interview. No money will be paid to you after the phone interview.

VI. Voluntary Participation & Withdrawal:

Taking part in this research is up to you. You do not have to be in this study. If you decide to be in the study and change your mind later, you can drop out at any time. During the face-to-face and follow-up interviews, you may skip questions or stop at any time.

VII. Confidentiality & Privacy:

We will keep your records private as required by law. Besides me, my thesis committee will have access to your information. A professional company will make a written copy of the audio recording. They will sign an agreement to make sure your information remains private. Your information may also be shared with those who make sure the study is done right (the GSU Review Board, the Office for Human Research Protection). To further protect your privacy, I will use a fake name instead of your real name on all published reports.

Interview recordings and any other information you give will be stored in a secure computer and locked file cabinets. Any personal information in audio and paper form will be kept for 5 years. After that, your information will be destroyed by deleting and shredding. Your name and other facts that might point to you will not appear when this study is presented or its results are published. Your identity and personal information will be kept private.

VIII. Contact Persons:

If you have any questions, concerns, or complaints about this study, you may contact Dr. Candace Kemp at 404-413-5216. You can also call if you think you have been harmed by the study. Call Susan Vogtner in the GSU Office of Research Integrity at 404-413-3513 or svogtner1@gsu.edu if you want to talk to someone who is not part of the study team. You can talk about questions, concerns, offer suggestions, or get information about the study. You can also call Susan Vogtner if you have questions or concerns about your rights in this study.

IX. Copy of Consent Form:

We will give you a copy of this form to keep for your records. If you agree to take part in this study and be audio recorded, please sign below:

Print your name

Sign your name

Date

Student Principal Investigator

Date

Appendix E: Interview Schedule

This study is about the “change of life” and the process of aging from your unique perspective, and we’ll get to those questions in a minute; but first, I’d like to start the interview by asking just a few questions about the status of your health in general.

General health status:

- Self-rated health response (review demo sheet)
 - Are you currently being treated for any chronic health conditions such as hypertension, diabetes, or heart disease? If so, please describe.
 - Are you currently being treated for depression, anxiety, or other mental health problems? If so, please describe.
 - What concerns do you have, if any, about your health in general?

Now, think back to when you were younger and tell me what you remember about your first menstrual period?”

Menstruation history:

- How old were you when your first period began?
 - Did you know what was happening?
 - How did you feel about it at the time?
 - What, if any, discomforts did you experience?
 - How did you manage the discomforts?
- What were you told (or what had you learned) about menstruation at about the time you first started?
- How regular were your menstrual cycles in your teens, 20s, and 30s?
- How have you felt in general about menstruation throughout the years?
- What are your menstrual cycles like now (in terms of regularity, flow, etc.)?

Perimenopausal signs & symptoms:

- Somatic changes, signs, and symptoms

- Tell me about any physical changes, signs, or symptoms you have recently experienced with your menstrual cycle?
 - Approximately how old were you when you first started to notice these changes?
 - How have these changes or symptoms progressed over time?
 - In what ways have you managed these changes or symptoms (e.g., take OTC meds or prescription drugs, alcohol)?
 - Do any of these changes or symptoms cause you psychological or emotional distress? Please explain.
 - How do you feel about the physical changes taking place in your body right now?
- In general, how do you feel about the changes (e.g., irregularity) in your menstrual cycle?
- Vasomotor symptoms
 - Do you have hot flashes or night sweats? If so, how often?
 - How do you handle these symptoms?
- Sleep problems
 - On average, how many hours do you sleep?
 - What sleep problems, if any, have you had over the past few years?
 - Do you have night sweats? Tell me about them.
 - Have you seen a doctor regarding sleep problems?
 - What did he or she recommend?
 - Did you adopt their recommendations?

- What have you tried on your own to improve your sleep?
- Mental/emotional changes
 - How has going through “the change” affected you mentally and emotionally?
 - Have you noticed any changes affecting your memory? If yes, please explain.
 - To what extent do you find it difficult to concentrate on tasks?
 - How have you addressed any memory or concentration problems?
 - Have you seen a medical professional regarding this concern?
- What other menopausal signs or symptoms have you experienced over the past few years?
 - How have you managed these symptoms?
- What other menopausal signs and symptoms, if any, have you experienced over the past few years?
- Since the change of life can take place over a number of years, do you feel you have all the resources you need, both internal and external, to successfully manage the menopause transition? Please explain.

The next set of questions relate to your personal attitudes and perceptions about the “change of life” and your personal views toward aging.

Perceptions and attitudes toward menopause & aging

- Personal views, perceptions, and attitudes:
 - What is it like going through “the change of life?”
 - Have you thought much about it?
 - What feelings do you have about it?
 - What does it mean to you personally?

- In general, how do you feel about getting older, and what meaning does it have for you?
 - What do you think influences your perception of aging (e.g., social media, ads, family, friends, men, etc.)?
- What thoughts do you have about being a black woman in midlife?
 - In what ways, if any, has being a black woman in midlife changed your opinion of yourself in terms of attractiveness or desirability?
 - In what ways, if any, has going through “the change of life” affected your overall self-esteem, or the way you see yourself?
- In your opinion, how, if at all, are black women’s change-of-life experiences similar or different compared to women of other races/ethnicities?
- What other thoughts do you have about the “change of life” and women’s aging?
- Knowledge of menopause and external sources of information:
 - What have you heard or learned about menopause so far?
 - What do you believe about the “change of life”?
 - What information about menopause, if any, was passed on to you from relatives and friends?
 - How did you feel about the menopause information you received from relatives and friends?
 - In what ways, if any, has this information changed your attitude toward menopause and aging?

- Have you sought information about menopause online?
 - If so, can you tell me about your online experiences?
 - (If she did not seek info online, why not?)
 - What websites have you visited?
 - What prompted you to go online?
 - What did you learn?
 - How helpful was the information?
 - What questions do you still have about the menopause transition?
- Have you read any books about menopause? Which ones? How helpful did you find them?

The next set of questions are about contacts you may have had with medical professionals concerning the “change of life.” So, any interactions you may have had with primary doctors, gynecologists, nurses, nurse practitioners, midwives, or other medical personnel regarding menopause, fibroid tumors, hormone replacement therapy, or any related concern.

Communications and interactions with medical professionals:

- At a routine check-up, did anyone ever initiate a conversation with you about menopause or the change of life? If so, tell me about that.
- When you sought information about menopause from medical professionals, what types of information did you receive?
 - How did you feel about the information you received. How helpful was it?
 - How comfortable were you with the medical professional’s response?
 - Did you have an opportunity to ask questions or address your concerns at that time? If not, how did you feel about that?

- Did you or the medical professional follow up after the initial discussion? Tell me about your follow-up contact.
 - What types of pamphlets or leaflets, if any, have you received from your doctor's office re: menopause? How helpful were they?
- Over the past few years, what types of medical services have you sought related to menopause (e.g., health clinic, emergency, urgent care, primary care physician, OB-GYN, nurse practitioner)?
- At times when you sought medical help for menopausal concerns, what were your experiences like (e.g., obtained helpful information, felt heard, or taken seriously)?
- Have you ever seen a doctor about heavy menstrual bleeding, hot flashes, night sweats, sleep problems, or other common menopausal symptoms?
- Have you ever been diagnosed with uterine fibroid tumors?
 - When was the diagnosis?
 - What information were you given about the fibroids?
 - What was the doctor's recommendation?
 - What was the outcome?
 - What, if any, follow-up visits have you had re: fibroids?
 - (If applicable) What concerns or fears do (or did) you have regarding the need for a hysterectomy?
- What do you know (or what have you heard) about hormone replacement therapy?

- Have you ever thought about getting (or asked a doctor) about the pros and cons of hormone replacement therapy?
- What do you feel you need, if anything, from medical professionals as you go through the “change of life?”

Healthcare challenges:

- Do you have health insurance? What type?
- Do you receive Medicaid?
- Do you feel you have adequate medical coverage?
- In what ways does your current coverage fall short?
- What concerns do you have about healthcare costs?
- How do you meet current healthcare costs?

Quality of life:

- In what ways has going through “the change” affected your daily life?
- What types of dietary changes, if any, have you made during the menopause transition?
- Do you exercise regularly? What types of activity do you engage in?
 - How helpful is exercise in managing the menopause transition?
- In what ways, if any, has “going through the change” affected your work life?
 - Have you missed work because of menopausal symptoms?
- Do you make time for self-care?
 - What kinds of things do you do?
 - How often do you engage in self-care?
 - Do you feel you could use more self-care?

- What do you feel you need, if anything, from significant others as you go through the “change of life?”

If the participant is married or sexually active:

- How has going through “the change” affected your sex life?
- How has the process of aging changed your view of sex?
- What conversations have you had with your partner about your change-of-life experiences?

Impact on interpersonal relationships:

- In what ways has going through “the change” affected your relationships with family members, friends, and even co-workers?

Closing question:

- Is there anything else we haven’t talked about today that you would like to add about your “change-of-life” experiences?

Appendix F: Transcriber Confidentiality Agreement

Study title: A phenomenological study of low-income black women in perimenopause

Principal Investigator (PI): Pamela Manley

Thesis Committee Chair: Dr. Candace Kemp

In the process of transcribing audio recordings of interviews for the above-referenced research study, I will have access to information that is deemed confidential and must not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant. **By signing this form, I acknowledge and agree that:**

1. I will not disclose or discuss any confidential information with friends, family, or others.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any confidential information except as properly authorized by the principal investigator.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information, even if the participant's name is not used.
4. I will not make any unauthorized transmissions, modifications, or inquiries of confidential information connected to the study.
5. I agree that my obligations under this agreement will continue, even after termination of the work I will perform.
6. I understand that any violation of this agreement may have legal implications.
7. I will only access or use systems or devices I am officially authorized to access; and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

By signing this document below, I acknowledge that I have read and understand the terms of this agreement, and I agree to comply with all the terms and conditions enumerated above.

Printed name of transcriptionist

Signature of transcriptionist

Date

Appendix G: Sample of Line-By-Line Analysis

Transcription details:

Date: 18-Mar-2018
Input sound file: INTERVIEW_CD_03162018.mp3

Transcription results:

Note: Comments in red reflect observational comments.

S1 00:07 Alright. So, Ellen, this study is about the change of life and the process of aging from your unique perspective. And we'll get to those questions in a minute. But first, I'd like to start the interview by asking just a few questions about your health in general. Um, are you currently being treated for any chronic health conditions such as hypertension, diabetes, or heart disease?

S2 00:29 Yes, hypertension. *Chronic health condition: hypertension*

S1 00:30 Okay, hypertension. And, are you currently being treated for depression, anxiety, or other mental health problems?

S2 00:37 No, not mental health problems, but I have other health problems.

S1 00:44 Do you have any concerns--or what concerns do you have about your health in general, at this point?

S2 00:48 Well, sometimes the, the concerns I have is very, um, normal, I would say, um, due to the medication that I take, um, about the depression, and the ups and downs of it. *In reference to the above question, apparently this participant does not view depression as a mental health problem.*

S1 01:06 Okay. Do you, um, uh, relate the depression to this time of your life, or is it--and you don't have to reveal what it's about, but do you, um, associate any, any of your depression to going through the change, or hormonal things, or--?

S2 01:22 No, not the, um, hormonal change, but, um, my health in general. *Depression is associated with other health concerns.*

S1 01:26 Okay, I see. Okay, but, uh, so it's pretty much the, the--as far as chronic health conditions, the hypertension is what, is concerns you? Or that's a problem that you've been, that you're taking medication for?

S2 01:38 No, I take medication for hypertension but that's not the concerns that I have. It's, um, with the, um, fibromyalgia and other cond—

um, problems that the doctors, um, relates to fibromyalgia. That's my concern. *Chronic health condition: fibromyalgia*

S1 01:56

Okay, I got you. Like, you don't have to get into specifics. I was just asking these general health questions of each participant. So now think back to when you were younger and tell me about what you remember about your first menstrual period. Um, how old were you when you had your first period?

S2 02:14

I was 18 years old, and it was and I remember it was—I remember it was very, very painful having, um, menstrual cycles.

Age of first menstrual period: 18

S1 02:23

Oh, 18. That's, that's uh kinda' late, I think. Yeah. Probably kinda' late. So how did, that's, that's different then. 'Cuz all your other friends who were younger were menstruating?

It is late, but not unheard of. It would have been helpful to refrain from judging that.

Appendix H: Sample Memo of Interview

Date: March 16, 2018

Participant: “Ellen”

Timeframe: 2:30 – 3:30 p.m.

Location: Undisclosed

Ellen is 49 years-old, fairly tall, about my height (i.e., 5’7”), and fair-skinned. Her brown hair was relatively short, relaxed, and curled. As we exchanged introductions, I was struck by this participant’s piercing gray eyes. Her demeanor was calm and measured. The interview revealed that Ellen is biracial—her biological mother is white, and her father is black. Ellen’s appearance is that of a light-skinned black woman. Racially/ethnically, Ellen identifies as “mixed.” For the purposes of my research, her race/ethnicity does not pose a problem. The fact that Ellen expressed interest in the study indicated she felt she would be a good fit, especially since she met all the other criteria.

Ellen was raised by her father and stepmother. She disclosed that her mother’s family disowned her, because her father was black. (Yes, racism and prejudice in America are alive and well.) I could tell from the participant’s responses that her relationship with her stepmother was strained while growing up. She reported her stepmother had not prepared her well for menstruation. Based on her responses, I gathered Ellen harbors some resentment toward her stepmother. While Ellen shared her first menstruation experiences and the lack of information, I made an insightful comment that many natural mothers fail to educate their young daughters about menstruation. Based on information I’ve gathered thus far in the study, participants’ mothers and other caregivers displayed little knowledge about menstruation themselves, which makes it easy to see why young girls enter womanhood ignorant about how their bodies work.

And based on what I've gathered so far, their ignorance about the female body persists into midlife.

Unexpectedly, a good portion of the interview was spent discussing the participant's general health problems, including a long-standing history of fibromyalgia, endometriosis, and fibroid tumors. In my view, Ellen's change-of-life experiences were somewhat overshadowed by accounts of ongoing health problems, depression, pain, and interactions with doctors in seeking treatment for these problems. It is important to note that, for the most part, Ellen has been largely dissatisfied with the care she has received from various primary doctors. She has felt dismissed, not heard, and not well understood. In addition, Ellen has never received concrete information about the menopause transition from healthcare providers.

Overall, I felt the participant provided good data about her lived experiences. She is a woman of faith and voiced strong views about womanhood and aging. Like other participants in the study, her knowledge about the menopause transition was sparse and misinformed. For instance, I had to define menopause and describe its progressive stages, as no one ever explained these things to her. Additionally, like other participants, Ellen has been operating under a garden variety of myths and misconceptions about this critical stage of life.